Vaginismus in the Irish Context:

A Grounded Theory Study

Maria McEvoy, B.A, MSc.

A thesis presented to Dublin City University for the Degree of Doctor of Philosophy

School of Nursing, Psychotherapy and Community Health

Dublin City University

Supervisors: Dr. Rosaleen McElvaney & Dr. Rita Glover

August 2021

Declaration

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of Degree of Doctor of Philosophy is entirely my own work, that I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

Signed: Maria McEvoy

Student ID No: 14212687

Date: 16th August 2021

Acknowledgements

Thank you to all of the participants for giving their time and support to this research project. To the professional participants, thank you for sharing your knowledge and experiences of supporting and helping women and couples experiencing vaginismus. To the couple participants, thank you for sharing your experiences with vaginismus in your relationships so that those who struggle with this difficulty would not feel so alone and know that this is not aa rare experience within Irish culture. By illuminating the common and diverse experiences of vaginismus it is hoped that the unnecessary shame and stigma associated with sexual difficulties will lessen and understanding, compassion and support will increase.

Thank you to my PhD supervisors Dr. Rosaleen McElvaney and Dr. Rita Glover for their outstanding supervision, their enthusiasm and support for the research from its earliest conception, and for their unwavering dedication and commitment to its completion throughout the years of the project. Thank you to Dr. Pamela Gallagher, panel advisor to the project, for giving her advice and support throughout the research process. Thank you to the DCU Healthy Living Centre for allowing me to use their facilities to interview participants and for offering couple participants their expert help and support.

Thank you to the members of the Belfast Trust, the Irish Fertility Counsellors Association and Milltown Physiotherapy Clinic for inviting me to give presentations to members about the research and for raising awareness of the project within their clinics. Thank you to Dr. Eimear Philbin-Bowman and the team at the Well Woman Clinics in Dublin who promoted the research within their clinic. Thank you to the Institute of Psychosexual Medicine for inviting me to one of their team meetings in the early stages of the project and for sharing their expertise of working with women with vaginismus with me.

Thank you to everyone who helped with raising awareness about the research especially in the recruitment phases. Thank you to journalist Deirdre O'Keefe who wrote articles for the Irish Times and Herald Health Supplement (August, 2018) and to features editor Maria Moynihan who wrote an article for the Irish Country Magazine (March 2019) to bring awareness to the research. Thank you to Sean Moncrieff, Presenter, and Claire Collins, Producer, of the Sean Moncrieff show on Newstalk for inviting me to come on the show to talk about vaginismus in January of 2018 and for promoting the website on their social media. Thank you to Martin Grogan and Tracey Tobin, co-editors of the HSE newsletter Sexual Health News that featured an article about the research in April 2018. Thank you to Jim Carroll, Editor of RTE Brainstorm, for posting my article about vaginismus on the Brainstorm social media platform in September 2018.

Thank you to my employer Waterford Institute of Technology for supporting the PhD by funding the fees of this postgraduate course. Specifically, I would like to thank Dr. Richard Hayes, former Head of School of Humanities, Dr. Suzanne Deneiffe, current Head of the School of Humanities, Dr. Michael Howlett and Dr. Michael Bergin, former Heads of Department of Applied Arts for supporting my return to postgraduate study.

Final thanks goes to my husband, Shane McDonald, who provided practical help in the recruitment and data collection phases by setting up the social media platforms to raise awareness about the project. These included accounts on Twitter and Facebook and a dedicated website www.vaginsimusresearchireland.com in order to give information about the research and the support services available in Ireland. I am very grateful for your love and unwavering support and enthusiasm throughout the project.

Table of Contents

Declaration ii

Acknowledgements iii

List of Tables viii

List of Figures ix

Abstract x

Chapter One: Introduction 1

Background, Rationale and Aims *1*

Methodology and Theory *4*

Chapter Outline *5*

Chapter Two: Literature Review 7

Vaginismus: Definitions, Classifications and Prevalence Rates *9*

Understanding Vaginismus as a Muscle Spasm *11*

Understanding Vaginismus as a Dysfunctional Muscle Spasm 14

Diagnosing Vaginismus using Physical Examinations: Implications for Practice 16

Understanding Vaginismus as a Functional Muscle Spasm 19

Medical Sex Therapy and the Treatment of the Muscle Spasm *23*

Systematic Desensitisation Therapy to Eliminate the Physical Spasm 23

Pharmacological Therapy to Eliminate the Physical Spasm 28

The Focus on the Ability to have Penetrative Sex as a Measure of Success 30

The Medicalisation and Compartmentalisation of Sex Therapy 34

Understanding Vaginismus from Psychosocial Perspectives *38*

The Role of Explicit and Implicit Attitudes in Vaginismus 39

The Role of Negative Sex-Related Experiences and Cognitions in Vaginismus 41

The Role of Culture, Education and Religious Orthodoxy in Vaginismus 43

The Role of Familial Attitudes in Vaginismus 53

Understanding Vaginismus in the Context of Interpersonal Relationships *55*

Understanding Vaginismus in the Context of Familial Relationships 55

Understanding Vaginismus in the Context of the Couple Relationship 59

Understanding Vaginismus in the Irish Context: Previous Studies *63*

Understanding Vaginismus in the Irish Context: The Current Study *66*

Chapter Three: Methodology 69

Choosing Qualitative Research *69*

Choosing Grounded Theory Methodology: Ontological & Epistemological Considerations *72*

Philosophical Roots of Grounded Theory 74

The Ontology and Epistemology of Classic Grounded Theory 74

The Ontology and Epistemology of Straussian Grounded Theory 76

The Ontology and Epistemology of Social Constructivist Grounded Theory 77
Comparing Grounded Theory Methods 78
Choosing Straussian Grounded Theory 79

Ethical Considerations ***81***
Participant Considerations 82
Researcher Considerations 91
Data Storage Considerations 94

Method ***96***
Sampling and Recruitment Criteria 96
Data Collection Design and Procedures 101
Analytic Strategies for theory development 110

Evaluation Criteria ***119***

Chapter Summary ***123***

Chapter Four: Results **125**

Protective Disconnection ***127***
Lack of Emotional Support from Caregivers 127
Pleasing Others and Denying Emotional Needs 137
Sex is Perceived as Threatening and Shameful 143
The Sexual Self is Experienced as Confusing and Threatening 150
Protective Disconnection Section Summary 159

Attempts at Connection ***162***
Experiencing Intimate Relationships as Emotionally Challenging 162
Accessing Accurate Information is Hit and Miss 167
Attempts at Connection Section Summary 179

Healing Connection Through Relationships ***181***
Experiencing the Relationship as a Way of Connecting with Disconnected Aspects of the self ... 181
Experiencing Therapy as a Way for Both Partners to Connect in the Relationship 186
Healing Connection Through Relationships Section Summary 199

Disconnection and Connection: A Developmental Theory of Vaginismus in the Irish Context ... ***201***

Chapter Five: Discussion **206**

Vaginismus as an Adaptive Response to Unmet Emotional Needs in the Family of Origin ... ***206***
Perceived Unmet Needs and Emotional Dysregulation 207
The Consequences of Unmet Emotional Needs for the Development of the Self 211
The Role of the Family and Culture in Affecting the Development of the Sexual Self ... 214
The Consequences of Unmet Emotional Needs for the Development of the Corporeal and Sexual Self ... 221
The Consequences of Unmet Emotional Needs for the Development of the Relational Self ... 226
Section Summary: Vaginismus as an Adaptive Response to Unmet Emotional Needs in the Family of Origin ... 228
Implications for Theory 228

The Experience of Vaginismus in the Couple Relationship ***230***

Finding Intimacy in the Absence of Penetrative Sex 231
The Role of the Partner in Maintaining or Resolving Vaginismus 234
Resolving Vaginismus Within the Couple Relationship 238
The Role of Intimate Relationships in Fulfilling Previously Unmet Emotional Needs 240
Implications for Theory 242

The Experience of Seeking Help for Vaginismus in the Irish Context **244**
Attempts at Breaking Down the Physical Barrier will Increase the Vaginismic Response 244
Family Doctors Need to Open up the Conversation about Sexual Wellbeing with Patients 248
Lack of Accurate Information about Vaginismus Prevents Help Seeking 250
Lack of Trained Professionals and Public Clinics are Barriers to Resolution 253
Implications for Service Provision 254
The Therapeutic Relationship can Help with Understanding and Overcoming Vaginismus 256
Healing Unmet Emotional Needs through Therapeutic Relationships 260
Implications for Practice 262

Chapter Conclusion **263**

Evaluating the Emerging Theory **264**

Limitations and Strengths of the Present Study **267**

Concluding Remarks **271**

References **273**

Appendix A: Recruitment Poster for Agencies **295**

Appendix B: Information Sheet for Professionals **296**

Appendix C: Information Sheet for Couple Participants **299**

Appendix D: Consent Form for Professional Participants **302**

Appendix E: Consent Form for Couple Participants **303**

Appendix F: Interview Schedule for Professionals **304**

Appendix G: Interview Schedule for Couples **305**

Appendix H: Interview Schedule for Couples Follow Up Session **306**

Appendix I: Screenshot of NVivo Database Exported to Excel Open Coding Analysis 29th August 2020 ..... **307**

Appendix J: Screenshot of NVivo Database Exported to Excel Context and Process Coding Analysis 29th August 2020 ..... **309**

Appendix K: Screenshot of NVivo Database Exported to Excel Context and Process Coding Analysis 29th August 2020 ..... **310**

List of Tables

Table 1: Summary of the Categorical Structure for Theoretical Development………….135

List of Figures

Figure 1: Protective Disconnection in the Irish Context……………………………………………170

Figure 2: Protective Disconnection & Attempts at Connection in the Irish Context…..189

Figure 3: Connection and Disconnection: A Non-Linear Developmental Theory of Vaginismus in the Irish Context…………………………………………………………………..…………..210

Vaginismus in the Irish Context: A Grounded Theory Study

Maria McEvoy

Abstract

Vaginismus is a common sexual difficulty that can cause distress for the woman, her partner and their relationship. Despite its universal prevalence, vaginismus remains under-researched. The most recent studies of vaginismus in Ireland were conducted forty years ago and since then there have been no known studies of what it is like to experience vaginismus or to seek help in modern day Ireland. This is the first known study to interview couples together about their experiences of vaginismus and help seeking in Ireland and the first study to incorporate both the perspectives of couples and healthcare professionals. The aim of the study was to build a theoretical model of vaginismus within an Irish context from the perspective of couples and health care providers. This grounded theory study used semi-structured interviews to explore the experience of vaginismus in Ireland. Ten couples who had experience of vaginismus in their relationship and eighteen healthcare professionals who work with women and couples experiencing vaginismus were recruited for the study. Data were analysed through the three coding stages of Straussian Grounded Theory. The results conceptualise the experience of vaginismus and help seeking as a process of disconnection and connection, a psychosomatic defence mechanism within a lifespan developmental model. This defence mechanism is illustrated by iterative phases of protective disconnecting from emotional and sexual feelings within the family of origin, attempts at emotional and sexual connection within the couple relationship and, finally, a healing connection with the emotional and sexual self within the safety of the couple and/or therapeutic relationship. These results provide a conceptual framework that can inform a sensitive and ethical approach when working with women and couples experiencing vaginismus.

Chapter One: Introduction

> There are definitely times when I don't feel normal…and I feel like I'm not a proper wife…I feel undervalued as a person in that I can't [have sex]. (Deirdre)

This introductory chapter provides an overview of the thesis, the research question and aims of the study, the methodology and a description of the chapters.

Background, Rationale and Aims

Vaginismus is an "involuntary contraction of the pelvic floor muscle group leading to painful and/or impossible vaginal penetration" (Heinemann et al., 2016). It is an often hidden and isolating experience for many women and couples. As a clinical phenomenon, it is associated with high levels of distress for those affected (Crowley et al., 2009) with a detrimental effect on sexual and general health (Cherner & Reissing, 2013), on the quality of intimate relationships and on the ability to have children (Cherner & Reissing, 2013). Vaginismus can have a profound impact on how a woman feels about herself, on her partner and on their relationship (Ward & Ogden, 1994). Vaginismus contributes to significant sexual, psychological and relationship distress for the woman and her partner (Bergeron et al., 2015).

One of the difficulties in understanding vaginismus lies in how to define the problem. Most medical definitions such as the one above, concentrate on the spasming of the vaginal muscles when intercourse is attempted, and emphasise the physical aspect of the difficulty to the exclusion of other aspects (McEvoy et al., 2018a). Whereas the medical model defines vaginismus as a sexual dysfunction, in psychological terms it can be recast as a functional spasm that is protecting the woman from anticipated harm (Borg et al., 2012; Fugl-Meyer et al., 2012). The perception of harm can stem from actual experiences of attempted painful intercourse or from the anticipation that a sexual encounter will be painful (Binik, 2010). The

understanding of vaginismus as either a medical problem or a manifestation of psychological protective processes has significant implications for how this issue is addressed in healthcare services.

Accurate prevalence rates for vaginismus are not routinely available (Spoelstra, 2017); where statistics are available, there are obvious cultural differences, with relatively high prevalence rates reported in Eastern cultures when compared with Western cultures. For example, in Turkey, Iran and Ghana, surveys of sexual pain that included vaginismus have reported rates of 43%, 27% and 68% respectively (Amidu et al., 2010; Oksuz & Malhan, 2006; Safarinejad, 2006). Comparative surveys in America, the U.K. and Denmark reported rates of 7%, 7% and 3% respectively (Laumann et al., 1999; Mitchell et al., 2017; Ventegodt, 1998). According to Oberg et al. (2004) these discrepancies highlight the need for more research on the impact of socio-cultural factors on the prevalence of vaginismus.

Rates of vaginismus at a psychosexual clinic in Ireland in 1979 have been reported at 42% representing an anomaly in Western and European statistics (OSullivan, 1979). According to O'Sullivan, this was the highest rate of vaginismus reported by a psychosexual clinic in Europe. No recent statistics exist for the Republic of Ireland regarding current rates of vaginismus, but surveys conducted in psychosexual clinics almost forty years ago estimated that vaginismus affected 5 in every 1,000 marriages (Barnes, 1986). O'Sullivan and Barnes concluded that it was difficult to know exactly how many couples are affected because feelings of shame and a reluctance to discuss sexual matters may prevent couples from seeking help; they suggest that the rates in the general population were conceivably higher. Although current prevalence rates are not available, some studies have indicated that vaginismus is still a significant concern for Irish women and couples. In a study by Relate (a relationship and psychosexual therapy support service), vaginismus was found to be the second most prevalent female sexual difficulty presenting at their services in Northern Ireland (Roy, 2002). The study presented in this thesis is the first in over thirty years to examine

vaginismus in Ireland and the first study to investigate the couple experience of vaginismus and help seeking. It also sought to identify the factors in contemporary Irish society that might contribute to vaginismus.

In order to understand vaginismus, Ng (2010) states that it must be explored at three levels; intrapersonal, interpersonal and cultural, the interpersonal level being the one that is the least explored. Heiman and Meston (1997) reported that none of the studies of vaginismus they reviewed had included couples, and when data are collected on couples the partners' data is typically underutilised for analysis. Vaginismus, for the most part, occurs in the context of a couple relationship and thus different blends of factors will contribute in unique ways to each couple experiencing it. The current study seeks to interview couples who were experiencing or had experienced vaginismus in their relationship together about their experiences of vaginismus and help seeking in Ireland and to include both datasets in the analysis. The study also incorporates the perspectives of couples with the perspectives of a range of health care professionals who work with women and couples to provide a broad overview of the diverse experience of vaginismus and help seeking in Ireland.

The aim of the study is to build a theoretical model of vaginismus within an Irish context from the perspective of couples and health care providers. Thus, the two research questions are: how do Irish couples experience vaginismus and seeking help, and how do professionals view and work with vaginismus? The overall aim of the research study is to build a conceptual model of vaginismus within an Irish context that can provide a greater understanding of the contributing factors and experiences of Irish women and couples and how they attempt to cope with and seek help for vaginismus. The objective of generating a theory of vaginismus is that it may have a beneficial impact for individuals, couples and health care providers that may lead to greater understanding of the condition and more sensitive responses by health care professionals.

Methodology and Theory

This study employs a Straussian Grounded Theory methodology that seeks to create a theory that is grounded in the data (Strauss & Corbin, 1998). The coding procedure allows for not only the description of the experience from the perspective of participants and an explanation of the processes involved, but also to situate the study in a particular sociocultural context, in this case Ireland, in order to create a substantive theory of vaginismus. According to Corbin and Strauss (2015), the purpose of the development of a theory is to provide understandings of both specific and diverse populations and situations, and should be applicable to real life situations to bring about real change. This research study not only seeks to build a theory of vaginismus within the context of Irish culture but to use that theory to raise awareness and understanding and to reduce the stigma of a sexual difficulty that is all too often hidden because of feelings of shame.

Interviews were conducted with eighteen professional participants who work with women and couples experiencing vaginismus and ten couples who had experienced, or were currently experiencing, vaginismus. Each of the interviews were transcribed by the researcher and analysed using Straussian grounded theory coding methods. The latest version of Straussian grounded theory method of grounded theory analysis outlines three stages of coding: open coding, context and process, and selective coding for theory development (Corbin & Strauss, 2015). Open coding allows for the fragmentation of the data to develop preliminary concepts that can be grouped around higher-level categories. The context and process stage allows the theory to go beyond descriptions and to provide explanations for phenomena by capturing patterns of behaviour (process) within certain conditions (context) by further synthesizing codes to connect sub-categories. The selective coding stage constructs broad categories that allow for the abstraction of results and the development of a theory. Each level of coding employs the constant comparison method that involves the simultaneous

collection and analysis of data and the construction of categories from the data itself, which gradually develops into a theoretical framework. A pattern of experience emerged from the data in this study that represented the experience of vaginismus for participants.

A substantive theory of vaginismus in the Irish context was constructed from the data and was conceptualised as a non-linear developmental model involving three interconnected processes. In the first process, vaginismus is represented as a protective disconnection from the sexual self that predated engagement in adult intimate relationships. The second process illustrates attempts at seeking sexual connection in an adult intimate relationship. The third process describes the experience of healing connection through relationships and connection with the sexual self. These three processes, namely, protective disconnection, attempts at connection and healing connection through relationships, capture an overarching process of connection and disconnection and provides both a description and an explanation of the development of vaginismus in the family of origin to its manifestation and resolution in the couple and/or therapeutic relationships.

Chapter Outline

The thesis consists of five chapters. The current chapter provides an overview of the thesis. Chapter two presents a critical review of the literature on vaginismus to date from different theoretical perspectives: medical, behavioural, cognitive, psychoanalytical, sociocultural and interpersonal. Chapter three provides a description of the philosophical, ethical and methodological considerations that inform the study, as well as a detailed description of the data collection and analytic procedures, guided by the latest version of Straussian Grounded Theory. Chapter four outlines the findings of the study, culminating in the presentation of a substantial theory of vaginismus in the Irish context. Chapter five discusses the key themes from the theory in the context of the existing literature and outlines

the implications for theory and practice. Finally, the contributions and limitations of the current study are considered.

Summary

This chapter provides a broad overview of the background, aims, rationale and methodology for the study and a description of the substantive theory of vaginismus to be presented in this thesis. The theory has a developmental context that traces the development of vaginismus from its origins in early childhood to its manifestation and resolution within the context of the couple and/or therapeutic relationship. The three processes of the theory protective disconnection, attempts at connection and healing connection through relationships elucidate the experiences of couples in Ireland who have experienced vaginismus in their relationship. It is hoped that this unique conceptualisation of vaginismus will lead to an enhanced understanding of its complexities and a more sensitive approach to treatment by professionals.

Chapter Two: Literature Review

Vaginismus is an often hidden and isolating experience for many women and couples. Accurate prevalence rates are not routinely available (Spoelstra, 2017), and there is limited research about the sexual functioning and behaviour of women with vaginismus (Cherner & Reissing, 2013). A critical review of the literature on vaginismus from 1985-2001 concluded that very few articles discussed precipitating or maintaining factors or the consequences for woman and couples (Wijma et al., 2007). There is also considerable diversity in the sources available, limiting the generalizability of the study findings reviewed. However, the few studies that exist suggest that this is a significant issue, worthy of further research. As a clinical phenomenon, it is associated with high levels of distress for those affected (Crowley et al., 2009) and it can have a profound impact on the woman, on her partner and on their relationship (Ward & Ogden, 1994).

Much of the literature focuses on vaginismus as a physical difficulty, defined in exclusively medical terms, concentrating on the spasming of the vaginal muscles when intercourse is attempted but that understanding fails to consider that the spasm may be secondary to other factors such as; fear of actual or anticipated pain when attempting intercourse (Binik, 2010), as well as intimate relationship dynamics or cultural influences (Tiefer, 2001b). The methodological and ethical implications of defining vaginismus in purely physical terms is critiqued in this chapter. One of the predictors of successful treatment for vaginismus is the attribution of the problem to psychological causes rather than physical ones (J.D.M. van Lankveld et al., 2010). These may include negative beliefs and attitudes towards sexual functioning and the role of cultural attitudes, education and familial attitudes to sex and sexuality. Thus, vaginismus can be more helpfully thought of as a multifaceted condition with individual, couple and cultural aspects (Meana et al., 2015).

This chapter attempts to review and to critique the literature in order to investigate what is known about vaginismus and where gaps exist in the literature in order to provide a rationale for the current study that seeks to build on previous knowledge. A comprehensive search of the following databases was conducted using the EBSCO Discovery Service multisearch tool used by Waterford Institute of Technology library and the Summon multisearch tool used by Dublin City University library: Academic Search Complete, Access Science, ACLS Humanities E-Book, American Medical Association (AMA), Annual Reviews, APA PsychInfo, APA PsycArticles, APA PsycTests, Applied Social Science Index and Abstracts (ASSIA), British Library, British Medical Journal, Cambridge Journals Online, CINAHL, ClinicalKey, ClinicalTrials.gov, Cochrane Library, Directory of Open Access Journals (DOAJ), Dissertation Abstracts, EBook Central, EBESCOhost (e-book collection), Emerald Insight, ERIC, HathiTrust, Hindawi, Electronic Theses Online Service (EThOS), JSTOR Journals, MedicinesComplete, Medline, OmniFile Full Text Mega, Open Library of Humanities, Ovid SP, PsycArticles, PsycBooks, PsychInfo, PubMEd, RIAN, Sage Journals Online, Sage Research Methods Core Collection, ScienceDirect, SciVal, Scopus, Social Science Premium Collection, Social Sciences Citation Index, SpringerLink, Taylor & Francis Online, UK & Ireland Reference Centre, Web of Science, and the Wiley Online Library.

The literature search used a fifty-five year timeframe (1966-2021) starting in 1966 when the first systematic study of the female sexual response was published by Masters and Johnson. This expansive time frame is appropriate to an exploratory study that attempts to draw together a comprehensive view of the phenomenon under investigation. The key words used in the initial searches were vaginismus, dyspareunia, genito-pelvic pain/penetration disorder (GPPPD), sexual pain, female sexual pain, painful sex, sexual pain disorders, female sexual dysfunction. A review of the references of key articles resulted in the inclusion of additional relevant theoretical literature on vaginismus. All sources were read in full and the

material was collated in terms of definitions, contributing factors and approaches to treatments.

Vaginismus: Definitions, Classifications and Prevalence Rates

Vaginismus is defined in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition) as a subset of genito-pelvic pain/penetration disorders identified by persistent or recurrent fear of painful vaginal penetration (APA, 2013). The vaginismic response evokes a phobic defensive contraction of the paravaginal muscles whenever intercourse is attempted (de Souza et al., 2018). Vaginismus is classified as primary if the problem is lifelong, secondary if intercourse has been possible in the past and is now impossible, global if the spasm occurs whenever penetration is attempted regardless of the circumstances, and situational when it only occurs under certain conditions (Crowley et al., 2009). Partial vaginismus represents a constriction of the pelvic floor muscles that obstructs and restricts, rather than closes and prevents, penetration (S. Dogan, 2009). Women with total vaginismus cannot tolerate any penetration whereas women with partial vaginismus can tolerate penetration but only with great difficulty and can experience pain (Crowley et al., 2009).

The most recent edition of the DSM-5 (APA, 2013) has changed the emphasis from a spasm-based definition of vaginismus to include recurrent, persisting and distressing difficulty with one or more of the following: vaginal penetration during intercourse, vulvovaginal or pelvic pain during actual or attempted intercourse, fear or anxiety about the experience of vaginal or pelvic pain as a result of sexual penetration, and a marked tensing of the pelvic floor muscles during attempted vaginal penetration. The previous categories of vaginismus and dyspareunia have been combined into a new category called genito-pelvic pain/penetration disorders (GPPPD). Despite these recent changes to the classification systems, much of the research cited below in the literature review has retained the term vaginismus as a meaningful

theoretical and clinical term. J.D.M. van Lankveld et al. (2010) has suggested that, due to the confusion caused by nosological changes, there is a case to retain the use of the traditional term vaginismus to facilitate research and clinical communication. Therefore, the word vaginismus is used throughout this thesis.

Relatively high prevalence rates are reported in Eastern cultures when compared to Western cultures in population-based surveys. In Iran, Turkey, and Ghana, the prevalence of women reporting sexual pain was 27%, 43% and 68% respectively (Amidu et al., 2010; Oksuz & Malhan, 2006; Safarinejad, 2006) compared with 7% in America (Laumann et al., 1999), 3% in Denmark (Ventegodt, 1998) and 7.5% in Britain (Mitchell et al., 2013). However, it is very difficult to establish accurate prevalence rates for vaginismus for a number of reasons. First, most of the information on prevalence rates comes from clinical surveys rather than population-based surveys and so prevalence rates are calculated from the number of women who attend clinics for help. Women who have not sought help are excluded from such statistics. The requirement of the gynaecological examination to diagnose vaginismus also makes epidemiological surveys more difficult (Binik et al., 1999). The focus on clinical populations presenting with vaginismus to calculate prevalence rates places limitations on the ability to collect accurate data that might elucidate the scale of the difficulty in the general population. More community based prevalence studies are needed to access those who do not seek help and are not linked in with the healthcare system (Bergeron et al., 2015). Second, professionals may miss opportunities to identify vaginismus if they are not aware of the problem or do not ask the right questions. A recent survey of assisted reproductive technology centers in Brazil and Latin America concluded that, when women asked for procedures under sedation, sexual dysfunctions such as vaginismus were not considered as possible reasons for problems with conception (de Souza et al., 2018). The authors stated that this missed opportunity for diagnosis affected the quality of care and support offered to these clients. Third, vaginismus tends to be a hidden problem because of

the shame and stigma attached to sexual difficulties and sex in general, in many cultures. Secrecy and guilt associated with vaginismus have been identified as factors that prevent the identification of reliable prevalence rates (Ogden & Ward, 1995). Fourth, the association between sexual abuse and vaginismus may exacerbate experiences of shame, which prevents women from seeking help (Ogden & Ward, 1995). Despite being often cited as a major contributing factor, few studies have demonstrated the link between vaginismus and sexual trauma (de Jong et al., 2009; J.D.M. van Lankveld et al., 2010). Nevertheless, research has identified that women have been hindered from going for counselling by a belief that such counselling would lead to the discovery of repressed childhood events (Ogden & Ward, 1995). Fifth, Binik (2014) has stated that much of the literature to date has focused on primary vaginismus and women with secondary vaginismus have largely been excluded. In addition, definitions of vaginismus and the characteristics of the sample used in the literature are often insufficiently described (Wijma et al., 2007). More clarity is needed in the literature in distinguishing between these types of vaginismus, given the implications for therapeutic response.

Understanding Vaginismus as a Muscle Spasm

The vaginal spasm has been the sole diagnostic criterion of vaginismus used for diagnosis for the last 175 years (Perez & Binik, 2016). Masters and Johnson (1970) were the first researchers to systematically study a range of sexual difficulties including vaginismus and recognised the reaction as psychosomatic because the muscle spasm was an involuntary reaction to either real or anticipated attempts at vaginal penetration. Despite their acknowledgement of both a physical and psychological component to vaginismus, they diagnosed the difficulty by the presence of the vaginal spasm only. They advocated treatments designed to eliminate the spasm and viewed the ability to allow penetrative intercourse as the sole outcome measure of treatment success. Current classification systems similarly seek to

identify biological markers that indicate the presence of an underlying mental disorder (Tyrer, 2014) and for vaginismus that marker has been the vaginal spasm (Binik, 2010). Early editions of classification systems of mental disorders such as the International Classifications of Diseases and Related Health Problems (ICD-10) Mental and Behavioural Disorders Section (WHO, 1992) and the DSM-IV-TR (APA, 2000) have relied on the vaginal spasm and Masters and Johnson's (1970) model of human sexuality to diagnose vaginismus (Shaw, 2001). The vaginal spasm is understood as dysfunctional from a medical perspective.

Perez and Binik (2016) have suggested that the spasm-based definition of vaginismus based on the Masters and Johnson model has persisted, not as a result of any empirical evidence, but as a result of the lack of critical attention to the variety of factors that can prevent intercourse. Basson (2011) designed an alternative model to the Masters and Johnson model of sexuality that incorporated emotional and cognitive aspects to more accurately represent the female sexual experience. In a more recent interview, however, Basson clarified that this model describes both the female and male sexual experience and stated that the Masters and Johnson model applies unfair heteronormative stereotypes to both sexes (Barmak, 2018). Based on Basson's revision of the female sexual response, later work suggested that rather than concentrating on the muscle spasm for diagnosis of vaginismus, a multidimensional diagnostic framework was needed that included non-arousing influences. Additional diagnostic markers might include abnormally high muscle tone, pain, fear of pain and behavioural avoidance (Reissing et al., 2004). Wylie and Mimoun (2009) advise caution in using any one model to represent a normative sexual response pattern, however, stating that models proposed by Masters and Johnson and Basson were based on clinical or volunteer studies and, thus, may not be a representative of the general population.

Recent revisions of classification systems such as the International Classifications of Diseases and Related Health Problems (ICD-11) Conditions Related to Sexual Health Section (WHO, 2020) and the DSM-5 of Mental Disorders (APA, 2013) have attempted to address

these issues by including changes to the definition of many sexual dysfunctions, including a move away from the spasm-based definition of vaginismus. The latest version of the ICD (11th Edition, World Health Organisation 2020) classifies vaginismus and dyspareunia under sexual pain disorders. The decision was based on the conclusion that there was inadequate empirical evidence to diagnose vaginismus due to the presence of a vaginal muscle spasm, and that fear of pain and penetration leading to phobic avoidance is often used in clinical descriptions of vaginismus. In 2013, the DSM (5th Edition; American Psychiatric Association, 2013) removed the separate diagnoses of 'vaginismus' and 'dyspareunia,' and encompassed both in a new category called genito-pelvic pain/penetration disorders (GPPPD). The reclassification occurred because research suggested that anxiety and avoidance were more reliable in distinguishing vaginismus from dyspareunia and that the vaginal spasm that was often a feature of both conditions (Meana et al., 2015). The signs and symptoms of GPPPD in the DSM-5 now include recurrent, persisting and distressing difficulty with one or more of the following: vaginal penetration during intercourse, vulvovaginal or pelvic pain during actual or attempted intercourse, fear or anxiety about the experience of vaginal or pelvic pain as a result of sexual penetration, and a marked tensing of the pelvic floor muscles during attempted vaginal penetration. In addition, the difficulty must persist for at least six months, cause significant distress and must not be attributable to significant stressors, including relationship stress or another medical condition (APA, 2013).

Although acknowledging that GPPPD is an empirically based and clinical useful improvement for the diagnosis of painful sex, Reissing et al. (2014) states that the inclusion of "marked tensing or tightening of the pelvic floor muscles" (APA, 2013, p. 437) in the diagnostic criteria of the DSM-5 is not sufficiently differentiated from the concept of "involuntary spasm of the musculature of the outer third of the vagina" (APA, 1994, p. 556) in the previous edition. Spoelstra (2017) also questions whether reference to a "rather vague notion of pelvic muscle tension or tightening in the current DSM is an improvement" (p.128).

Although the categories of lifelong and acquired GPPPD have been included as specifiers in the DSM-5, Reissing et al. (2014) highlights that the current diagnostic criteria do not include the experiences of women who have never been able to have penetrative intercourse (lifelong vaginismus). M. ter Kuile and Reissing (2014) state that, without additional research on lifelong vaginismus, it may be premature to conclude that vaginismus and dyspareunia are the same disorder and to combine their diagnoses in DSM-5. Reissing et al. (2014) suggest that "vaginal intercourse has never been possible" should be included as a specifier to the GPPPD diagnostic criteria (p. 1213). Expanding the definition of vaginismus, in particular to include anticipatory fear or anxiety, is welcomed by authors who see this as an opportunity to investigate the deeper emotional meanings behind the physical symptom (T. Rosenbaum, 2018; Shaw, 2001). The DSM-5 also includes five factors that may contribute to GPPPD, namely partner factors, relationship factors, individual factors, cultural and religious factors and medical factors (APA, 2013). The new definition of vaginismus in the ICD-11 has been criticised, however, because it does not allow for the influence of cultural and psychosocial factors and has yet to fully incorporate a biopsychosocial perspective (Parameshwawran & Chandra, 2019).

The scientific and clinical usefulness of the new GPPPD spectrum diagnosis has yet to be investigated (Perez & Binik, 2016). The predominant therapeutic response to individuals experiencing vaginismus, as will be demonstrated in this chapter, continues to focus on the physical spasm, rather than the range of potential aetiological factors that contribute to the difficulty. The implications of understanding vaginismus as a dysfunctional muscle spasm is described and critiqued in the following sections.

Understanding Vaginismus as a Dysfunctional Muscle Spasm

From a medical perspective, the muscle spasm associated with vaginismus is considered to be dysfunctional because it causes the muscles of the perineum and outer third of the

vagina to contract in an involuntary spasm, impeding the rhythmic contractions normally associated with sexual excitement (Masters & Johnson, 1970). The degree of severity of the involuntary spasm can be measured using the four point Lamont classification system (Lamont, 1978). The first degree is a perineal and levator spasm, which can be alleviated with reassurance, the second is a perineal spasm which is maintained throughout examination, the third is a levator spasm with elevation of buttocks and the fourth degree includes levator and perineal spasm, buttock elevation, adduction and retreat. More recent studies identified a more severe manifestation of the vaginismic response to routine gynaecological examination that has been assigned an additional grade five rating to the Lamont Scale (Pacik, 2011; Pacik et al., 2018). This reaction is characterised by a "visceral reaction manifested by a combination of crying, screaming, shaking, trembling, hyperventilating, sweating, experiencing nausea, vomiting, "going unconscious," "wanting to jump off the table" and "wanting to attack the doctor" (Pacik, 2011, p. 1162).

The centrality of the muscle spasm in understanding vaginismus is illustrated in the reliance on the physical examination as a core method of diagnosis. Masters and Johnson (1970) stated that it was impossible to diagnose vaginismus without a physical examination to confirm the muscle spasm and prioritised the muscle spasm as the primary defining feature of vaginismus. Helen Singer-Kaplan proposed that in order to differentiate a phobia from a possible physical abnormality, a physical examination was necessary for diagnosis of vaginismus (Singer-Kaplan, 1974) again designating the muscle spasm as the sole method of identification. As recently as 2015, the Fourth (and most recent) International Consultation on Sexual Medicine, Sexual Dysfunctions in Men and Women, defined vaginismus as a vaginal muscle spasm that either prevented intercourse or caused it to be painful (McCabe et al., 2016).

Diagnosing Vaginismus using Physical Examinations: Implications for Practice

Concerns have been raised about the reliance on the physical examination as a diagnostic method for vaginismus as it might lead to false positive identification when used to the exclusion of other factors. For example, if situational vaginismus is present, the muscle contraction may occur during physical examinations but not during intercourse (Binik, 2010). There is little evidence to indicate whether the inability to tolerate a physical examination is any indication of the ability to have sexual intercourse (Parameshwawran & Chandra, 2019; Reissing et al., 2004). Helen Singer-Kaplan (1974) identified that women with vaginismus quite often were phobic of real or imagined sexual intercourse or penetration. This phobia could be secondary if it occurs as a result of the vaginismic response, or primary if it is the root cause of the vaginismic response. Without knowing whether the phobia is primary or secondary, the insistence on a physical examination may intensify and generalise the phobic response (Oniz, Keskinoglu & Bezirioglu, 2010). Examinations to confirm muscle spasms are often impossible to conduct with patients because of the high levels of anxiety they provoke (Binik et al., 1999; Reissing et al., 2014). Feelings of threat can elicit pelvic floor reactions in all women with vaginismus rendering a physical examination impossible (van der Velde & Everaerd, 2001). Masters and Johnson conceded that examinations may be impossible without "employing severe force" and this could cause trauma that would have a negative effect on any subsequent attempts at therapy (Masters & Johnson, 1970, p. 251). Physicians' rigid adherence to protocols, lack of knowledge and pathologising of vaginismus, has been linked to increased patient anxiety (Oniz et al., 2007; T.Y. Rosenbaum & Padoa, 2012). Common experiences reported by women with vaginismus include being dealt with abruptly by health practitioners and being admonished for preventing examination leading to further anxiety and shame (Valins, 1988). Often, women with vaginismus are very motivated to cooperate with the examination but, if examination is carried out insensitively, dissociation (potentially

misinterpreted by the physician as cooperation) may occur, leading to a further decrease in the woman's sense of autonomy and control (T.Y. Rosenbaum, 2013). If the experience of the physical examination is perceived negatively, this may exacerbate the problem and negatively interfere with later attempts at therapy (Barnes, 1986a).

A warm, empathic, patient and understanding attitude from physicians and the establishment of rapport prior to any physical examination is crucial to success (Biswas & Ratnam, 1995; Fugl-Meyer et al., 2012). Successful resolution of sexual dysfunction, including vaginismus, by primary care physicians have been reported where the physician has an open and receptive attitude and an ability to combine psychological treatments with physical ones (Ng, 2001), and has empowered the woman by including her in decisions regarding her care (T.Y. Rosenbaum & Padoa, 2012). It is important that both the healthcare professional and the woman understands the reason for the intimate examination (Khan-Singh, 2019). When the concerns of a woman are listened to by health professionals and appropriate modifications are made to accommodate her concerns, the woman's experience of pelvic examinations are more positive (T.Y. Rosenbaum & Padoa, 2012). Doctors who wish to perform an examination are advised to explain the purpose of the examination and, if necessary, to employ systematic desensitisation to allow the examination to be done gradually so as not to further traumatise the patient (Crowley et al., 2006).

The psychosexual therapeutic genital examination is at the core of psychosexual medicine, using intimate contact as a way of opening the conversation about the patient's innermost fears (Khan-Singh, 2019). It has been proposed that, rather than routinely using physical examinations and risking further trauma in the process, it should instead be employed in cases where pain is experienced when attempting intercourse in order to reassure the woman who may be concerned that the problem might be physical (Basson, 2008a), or to teach pelvic floor relaxation exercises (Crowley et al., 2009), or as a therapeutic opportunity for the woman to speak about her fears regarding penetration (Khan-Singh, 2019). For

example, in one study, women with primary vaginismus rated a pelvic exam as very helpful when it was utilised in the context of psychosexual education (Reissing, 2012). Mindfulness techniques have also been employed to help women diagnosed with sexual pain to stay present during examinations and to deal with the anxiety, rather than dissociating from it (T.Y. Rosenbaum, 2013).

There is evidence however, that doctors' perception of the therapeutic benefit of pelvic examination may not be shared by their patients. A study by Menage and Counselling (1993) that surveyed 500 women about their experiences of obstetric and gynaecological experiences revealed that over 20% said that their experiences were distressing and terrifying and 30 of these women were considered to meet the DSM criteria for post-traumatic stress disorder. These women disclosed experiences of a lack of informed consent, feelings of powerlessness, the experience of physical pain and an unsympathetic attitude by the healthcare professional. A recent paper by the American Medical Association concluded that the harm caused by routine pelvic examinations including, "discomfort, anxiety, psychological effects, embarrassment, and unnecessary procedures including surgery," far outweighed any potential benefits (Morgan et al., 2015, p. 1961).

Further, there is controversy over whether it is appropriate to diagnose a woman who cannot have intercourse with a sexual dysfunction, unless she also experiences subjective distress (Basson et al., 2003; Drenth, 1988). The distress observed during examination and self-reported levels of distress during examination and intercourse may be more central to diagnosing vaginismus than the muscle spasm (Crowley et al., 2009). In one study, psychologists who were only given self-reports from patients without meeting them were as accurate at diagnosing vaginismus as gynaecologists or physical therapists that had examined (or had attempted to examine) the patient and had seen their defensive behaviours first hand (Reissing et al., 2004). In 2001, the Working Group on the New View on Women's Sexual Problems recommended a social constructionist model of diagnosis that allows women to

identify their own sexual problems which they defined as "discontent or dissatisfaction with any emotional, physical or relational aspect of sexual disorder" (Tiefer, 2001b, p. 91). The lack of standardised tests available for the self-reporting of vaginismus (Binik, 2010) or validated sexual distress-specific instruments in order to measure personal distress means that vaginismus is still routinely diagnosed by purely physical examination (Basson et al., 2000). The most recent version of the DSM, however, takes this into account and requires that significant distress be identified as a specifier for diagnosis of GPPPD (APA, 2013).

Understanding Vaginismus as a Functional Muscle Spasm

In contrast to the medical understanding of vaginismus, behaviourists assume that sexual disorders are functional, rather than organic (Krueger & Piasecki, 2002) and the function of vaginismus may be as a phobic reflexive response to protect the individual against actual, perceived or anticipated harm from vaginal penetration (Borg et al., 2012; Fugl-Meyer et al., 2012). Thus, the vaginismic response may be conditioned through, for example, painful sexual experiences or secondary to psychological or emotional factors (Basson et al., 2000; Berman et al., 1999).

In 1999, the first population-based assessment of sexual dysfunction in America since the 1950s Kinsey report, highlighted that not only were sexual dysfunctions extremely common but, in most cases, were linked to stress (Laumann et al., 1999). Feelings of threat can elicit pelvic floor reactions in all women, with or without vaginismus, indicating that the involuntary spasm of the pelvic floor may be part of the wider defence reaction of the body to stress (van der Velde & Everaerd, 2001). The pelvis and pelvic floor receive neural input from both the autonomic nervous system's sympathetic and parasympathetic divisions that mediates the sexual response cycle proposed by Masters and Johnson (Masters & Johnson, 1966; J.D.M. van Lankveld et al., 2010). Thus, pelvic contractions can be directly affected by stress or threat (J.D.M. van Lankveld et al., 2010).

Higher levels of stress and internal perceptions of stress have been identified in women with vaginismus (Bodenmann et al., 2006). Neurophysiological studies of women with vaginismus have identified prolonged spontaneous muscle activity and higher tone in the pelvic floor muscles even at rest, and an increased excitability of the pudendal-nerve (the main nerve of the perineum), which might lead to the spasming of the pelvic floor muscles (Engman et al., 2004; Frasson et al., 2009). Women with vaginismus have been found to score higher on tests of anxiety, and anxiety-proneness has been identified as a risk factor for vaginismus (Watts & Nettle, 2009). Studies such as these do not, however, indicate the direction of causality; whether this involuntary spasm is the primary cause of vaginismus or whether the spasm is a symptom of the condition or related to anticipatory anxiety or a reaction to fear of pain.

Relevant to the focus on stress, some comparative studies have also highlighted important differences between vaginismus and dyspareunia, the two sexual disorders that have been combined to form the new category genito-pelvic pain/penetration disorder (GPPPD) in the recent version of the DSM. Studies have found that the women with vaginismus showed more fear, distress, muscle tension and avoidance of vaginal intercourse than women who experienced painful sex (dyspareunia) or women who have pain-free intercourse (Basson et al., 2004; Lahaie et al., 2015). According to Melles et al. (2016) there are distinct differences between women with vaginismus and dyspareunia in coping with attempts at penetration; women with vaginismus are more likely to use avoidance strategies. Specific phobias have been reported by women with vaginismus related to bleeding, penetration, somatic injury and childbirth and an unwillingness to engage in coitus due to the possibility of pain (Crowley et al., 2009; Farnam et al., 2014; Hawton, 1985; Konkan et al., 2011). When compared with women with dyspareunia, Borg et al. (2012) found that women with primary vaginismus are also more likely to catastrophize their pain reactions.

Feelings of disgust have been found to be an important trigger for the vaginismic spasm. When compared with women with dyspareunia, some studies have shown that women with vaginismus report stronger negative appraisals of sexual stimuli (de Jong et al., 2009; Huijding et al., 2011), including feelings of disgust that can be measured by facial expression and also self-reports (Borg et al., 2010a). Some women also reported fear of contamination but only when the source of contamination was someone unknown to them and was not reflective of their feelings towards their partners (de Jong et al., 2009). Some women with vaginismus have been found to respond to sexual stimuli with more disgust than women with dyspareunia including increased levator activity, suggesting that one component of vaginismus may be a disgust-induced protective response (Borg et al., 2010a; de Jong et al., 2009; van Overveld et al., 2013). Jeng (2004) found that women with vaginismus experience shame, dislike and disgust reactions toward their own genitals. It has been suggested that the association between sex-related stimuli and disgust are automatic and uncontrollable and elicit defensive reactions (Borg et al., 2010a). One study found that women who experience sexual pain attend less to erotic scenes, and engage in active avoidance by looking away (Lykins et al., 2011).

Fear of pain is also a significant factor in understanding vaginismus as a functional muscle spasm and has been rated in surveys as the number one subjectively reported reason for vaginismus (Reissing, 2012; Ward & Ogden, 1994). This anticipation of pain can result in hyper-vigilance towards and negative appraisal of sexual cues and avoidance behaviours, which can result in lifelong vaginismus (Borg et al., 2012). These findings provide empirical support for understanding this condition as being phobic in nature and related to the anticipation of pain rather than to actual pain experiences (Klaassen & Ter Kuile, 2009; Reissing et al., 2004). Some women who experience vaginismus also report actual pain experiences (Reissing et al., 2004) even when they have not been able to endure penetration (Kaneko, 2001). For some women with vaginismus, the fear of feeling pain during intercourse

accompanied by fear of somatic injury might trigger a threat response that includes a spasmic response of the vaginal muscles (Konkan et al., 2011). A more recent study however, found that hypervigilance for sex-related threats including pain does not increase coital pain or avoidance behaviours in women with GPPPD, but may interfere with sexual arousal (Melles et al., 2016).

The limbic system in the brain, that is triggered by threatening situations, produces emotional responses and stores emotion-related information, regardless of whether the threat is actual or imagined and can be activated even if someone anticipates a threat, for example, through a conditioned response (Soeter & Kindt, 2012). Within the limbic system, the amygdala is involved in the regulation of the fears and safety emotions inherent in the sexual arousal response (Salu, 2013). Anxiety which has been associated with anticipated penetration can trigger the activation of the limbic system and the involuntary spasm of the pelvic floor (Weijmar-Schultz et al., 2005), leading to a protection of the inside space through muscle contraction, as in the case of vaginismus (Hiller, 2000). With regard to vaginismus, the immediate relief from anxiety triggered by avoidance reinforces further avoidance behaviours (Crowley et al., 2006). This understanding of vaginismus is compatible with the fear avoidance model of chronic pain (M. ter Kuile & Reissing, 2014), which states that catastrophic thinking related to vaginal penetration or anticipated negative experiences with vaginal penetration leads to fear and avoidance of all activities that may lead to vaginal penetration.

Studies have shown strong links between vaginismus, anxiety and phobic avoidance (Farnam et al., 2014) suggesting that, rather than being a physical dysfunction, the muscle spasm may be understood as a functional response to threat that protects the woman from real or perceived potential harm.

Medical Sex Therapy and the Treatment of the Muscle Spasm

How vaginismus is understood has implications for intervention. Medical and behaviour-based sex therapies, both historical and contemporary, tend to focus on the Masters and Johnson (1970) model of therapy as a theoretical foundation (R.C. Rosen & Leiblum, 1995; Yasan et al., 2009a). With regard to the treatment of vaginismus, because the focus is on treating the inability to tolerate penetrative sex, these therapies employ systematic desensitisation techniques combined with exercises for vaginal dilation, such as digital penetration and vaginal trainers (Jeng et al., 2006) and, in some cases, the use of a surrogate partner (Ben-Zion et al., 2007). More recently the application of muscle relaxants have been advocated (Fageeh, 2011). Studies of the effectiveness of these treatments in the literature generally report high success rates (Ng, 1988) and are discussed and critiqued in the following sections.

Systematic Desensitisation Therapy to Eliminate the Physical Spasm

Helen Singer-Kaplan noted the importance of concentrating on the current and immediate psychological antecedents of sexual dysfunction which she referred to as the "common final pathway," rather than deeper intrapsychic (psychodynamic) conflicts that may be the ultimate cause but, in her view, had little to do with current treatment (Singer-Kaplan, 1983, p. 4). She advocates a behaviourist orientated treatment, within the framework of the Masters and Johnson model. The focus of behavioural therapy is to counter-condition the fear response to sexual stimuli by reducing avoidance behaviour and engaging with graduated and prolonged exposure to the feared stimulus combined with relaxation techniques (M.M. ter Kuile et al., 2007), although caution is advised in the case of exposure therapy, e.g. conducting a full examination, due to its intrusive and potentially trauma-causing potential (J.D.M. van Lankveld et al., 2010). A study by Melles et al. (2013), however, reported that therapist-aided exposure treatment was successful in reducing subjective fear of sexual

penetration and increased positive associations with sexual stimuli. The effect, however, was limited as self-reports indicated that sexual stimuli following the exposure treatment was still more negative than those of women without vaginismus. According to Singer-Kaplan (1983), it is important to treat the secondary phobic avoidance before the muscle spasm as treatment is unlikely to be successful if the approach of any object towards the vagina causes panic. Systematic desensitisation is a graded technique used to overcome penetration anxiety and usually involves a progression from encouraging the patient to look at her genitalia, Kegel exercises to learn to control the spasm, and attempts at penetration using fingers or vaginal dilation (Crowley et al., 2009; Jeng et al., 2006). The goal of systematic desensitisation is to learn to associate sexual stimuli as erotic rather than threatening (Ng, 2001). A study by M.M. ter Kuile et al. (2009) found that therapist-aided exposure for women with primary vaginismus led to a significant reduction in coital fear and avoidance behaviours that had been maintaining the difficulty, and an increase in successful coital attempts. The authors concluded that erroneous cognitions and negative penetration fears could be disconfirmed by reducing avoidance behaviours. However, the authors were not able to say with certainty whether the improvement was due to the therapist-aided exposure, the degree of involvement of the partner or frequency of practice. Two Cochrane Reviews revealed that the high rates of success of systematic desensitisation for vaginismus often come from the publication of small sample sizes or single case studies, unreported drop out rates, and a lack of long term follow up data (McGuire & Hawton, 2009; Melnik et al., 2012). The authors concluded, based on their review, that there was little evidence to recommend the use of systematic desensitisation for vaginismus.

Masters and Johnson (1970) stated that vaginismus could be easily resolved by systematically inserting dilators of graduated sizes and reported a 100% success rate for this method. One study that compared the efficacy of training women with vaginismus to dilate the vagina using fingers or dilators found that there was more drop out in the finger training

group because of fear of self-touch, shame and disgust (Aslan et al., 2020). The authors speculated that the women trained to use dilators were more successful because it overcame fears of self-touch. The use of vaginal dilators as a sex therapy technique has been criticised, however, as it treats the physical aspect of vaginismus only (Binik et al., 1999; Binik et al., 2001). Some patients report that the use of dilators can result in more intense pain and unsuccessful attempts at intercourse, especially if relaxation exercises and gradual accommodation are not practiced in adjunct physiotherapy (Bergeron & Lord, 2003). Other practitioners have grave concerns about the coercive use of dilators and of penetrative intercourse as the marker of a successful outcome without considering whether emotional development has also occurred (Ng, 2001). A recent qualitative study of the experiences of women with vaginismus and use of dilators by Macey et al. (2015) found that professionals often underestimated the practical and emotional demands of the therapy on the women. Some of the women felt that they did not get adequate instruction and some were encouraged to persist with dilator therapy in ways that caused pain. Some of the women said they felt lonely and isolated by the therapy, especially when they had to confront wider issues of penetration difficulties and how it related to their sense of self. The women questioned the benefit of using dilator treatment without adequate support or information. T. Rosenbaum (2018) has argued that using physiotherapy to reduce tension in the pelvic floor without considering other elements such as the emotional state of the woman is reductionist and potentially harmful.

Physiotherapy can be used in conjunction with behavioural therapies to treat vaginismus by decreasing the fear of pain and penetration and increasing control over muscles (T. Rosenbaum, 2011) but the use of physiotherapy alone may not be effective (T. Rosenbaum, 2018). Reissing et al. (2013) found that symptoms such as pain, anxiety, fear, sexual distress, pelvic floor tension and impaired sexual function remained despite the ability to tolerate penetration following physiotherapy for women with primary vaginismus. This may be due to

the finding that the exercises prescribed have little impact on tension of the pelvic floor and that, more importantly, women are not even aware of what a tense pelvic floor feels like unless biofeedback and coaching is also utilised (Bergeron & Lord, 2003). Successful participation in physiotherapy for sexual dysfunction depends upon the approach of professionals (Ozdemir et al., 2008). One difficulty is that physiotherapy is often offered in a compartmentalised way, purely for the treatment of dysfunctional vaginal muscles, as opposed to a multidisciplinary model that encourages communication between all of the practitioners involved in treatment, not only regarding different facets of the problem, but the diversity of treatments provided and mutual feedback to enhance outcomes (T.Y. Rosenbaum, 2005; T.Y. Rosenbaum & Owens, 2008). Rosenbaum notes that referrals to physiotherapists be combined with psychotherapy and/or sex therapy to concurrently deal with anxiety, dissociation or relationship dynamics that might not be evident in the physiotherapy session (T. Rosenbaum, 2018). Rather than offering physiotherapy as a treatment for a spasming vaginal muscle, it could be advocated as an adjunctive treatment to therapy for reducing anxiety related to penetration (T. Rosenbaum, 2011; T.Y. Rosenbaum, 2005).

Systematic desensitisation exercises for the woman typically progress to mutual touching exercises for the couple called sensate focus (Masters & Johnson, 1970). The initial purpose of sensate focus is to give an opportunity to take the time to experience sensuality and pleasure without the pressure of intercourse and to facilitate improved marital communication. Sensate focus can provide couples with experiences of tuning into sensations and away from performance in the sexual encounter, and provide important therapeutic information for therapists (Weiner & Avery-Clark, 2014). Pacey (2018) however, cautions against the teaching of sensate focus as a behavioural programme without recourse to the emotional impact on partners. Given that the best predictors of sexual distress are feelings of negative general emotional well-being and a disconnect in the emotional relationship between the partners during the sexual encounter (Bancroft et al., 2003), sensate focus exercises often

raise and exacerbate underlying anxieties for both partners which can be mediated by the skills of a supportive therapist (Bancroft, 2009). For example, Meana (2009) states that if a partner interprets sex-avoidance as a lack of attraction, interest or commitment from his partner, his reaction is likely to either be to exert pressure or to withdraw. The therapist can deal with the anxieties including fears of abandonment, fears of intimacy and feelings of inadequacy. Sensate focus techniques can be used to build desire and arousal as well as communicating sexual preferences and giving corrective feedback in order to re-establish a sexual connection.

In certain contexts, the services of a surrogate partner may be recommended when a woman cannot progress to intercourse because she is single or does not have a cooperative partner (Ben-Zion et al., 2007; Masters & Johnson, 1970; T. Rosenbaum et al., 2013). In certain cultures, the surrogate is suggested in the case of the male partner being uncooperative in sex therapy or having a sexual dysfunction of his own (Ben-Zion et al., 2007) rather than tackling the communication problems or the male sexual dysfunction within the relationship. A woman's feelings for her partner play a very significant role in female sexual desire and desire can be affected by a change of sexual partner (Basson, 2008b). Therefore, any results from treatments including a male surrogate may not be indicative of a woman's ability, in general, to consummate a relationship or to enjoy sexual intercourse. Masters and Johnson employed female surrogates for some male patients but did not employ male surrogates for female patients and then abandoned the practice altogether (Bancroft, 2009). There are also controversial professional, legal and ethical implications of surrogate use to consider (Binik & Meana, 2009; T. Rosenbaum et al., 2013) and officially the use of surrogates in sex therapy is no longer sanctioned (Binik & Meana, 2009). Sexual surrogacy, however, is still a legal and accepted practice in Israel (T. Rosenbaum et al., 2013).

Kleinplatz (1998) cautions that the use of systematic desensitisation techniques may ultimately result in alienating a women from her own body and teaching her to ignore her

physical and emotional needs. For example, self-dilation is used to encourage the gradual relinquishing of control over penetration from the woman to the partner over the course of therapy (Jeng et al., 2006) but there are concerns that these procedures may further infantilise and disempower women who are trying to understand their sexuality (T.Y. Rosenbaum, 2013). Sensate focus has been criticised for being too focused on physical performance and dividing the body from the mind when treating sexual difficulties (Pacey, 2018). In their original studies with couples, Masters and Johnson (1970) themselves found that this focus on performance increased performance anxiety and decreased arousal. Participants who were more successful in arousing their bodies' pleasurable sexual response were more likely to use sensate focus for their own pleasure rather than their partners', focused on sensations, and redirected attention back to these sensations when their mind was distracted. Participants whom Masters and Johnson identified as spectatoring, were more likely to focus on performance from a third person perspective in the sexual encounter and to experience reduced sexual arousal and satisfaction. Although Masters and Johnson identified spectatoring as the primary focus of sensate therapy, this cognitive focus has largely been ignored or treated as supplemental (Linschoten et al., 2016). Sensate focus has been criticised for ignoring the impact of relationship dynamics on sexuality but can also be utilised as an opportunity to increase erotic closeness and experience intimate connection (Weiner & Avery-Clark, 2014) and to identify and resolve relationship problems such as difficulties with communication (Linschoten et al., 2016).

Pharmacological Therapy to Eliminate the Physical Spasm

Botulinum toxins, topical lignocaine, local anaesthetics and oral medications have been advocated to relax vaginal muscles to allow penetration and have reported instant results (Fageeh, 2011; Harish et al., 2012; Lodise, 2017; Pacik, 2011; Praharaj et al., 2006; Velayati et al., 2019). A recent systematic review of treatments for sexual pain disorders, however,

concluded that topical and systemic medical treatments generally do not lead to a complete relief of pain and side effects were very common (Al-Abbadey et al., 2016). Surgical procedures, such as the removal of the hymen is no longer recommended due to chronic psychological consequences (Barnes, 1986a; Coppini, 1999) and its detrimental effect on further treatment (Biswas & Ratnam, 1995; J.D.M. van Lankveld et al., 2010) but it is still used in some countries, including India (Harish et al., 2012). Surgery impacts negatively on possible successful treatment because it both reinforces the idea for the woman that vaginismus is related to a physical abnormality, and excludes the partner from the treatment process (Barnes, 1986a).

It is not clear from the literature which pharmacological treatments are most effective (Pereira et al., 2013) and use of anti-depressant medication can exacerbate the symptoms of sexual difficulty (Lorenz et al., 2016). There is more data available on the neural and neurochemical correlates of sexual dysfunction in men than women (Basson & Weijmar-Schultz, 2007). In 2000, The International Consensus Development Conference on Female Sexual Dysfunction acknowledged that women's sexual dysfunction was poorly understood and difficult to assess (Basson et al., 2000) but this report, funded by the pharmaceutical industry, ignored sociocultural factors in favour of physical therapies and pharmacological treatment (Tiefer, 2001b). More recently there has been a surge of interest in developing pharmacological treatments for female sexual dysfunction including Flibanserin (Lodise, 2017; Vegunta et al., 2016) due to the profitable marketing of Viagra for male impotence (Bancroft et al., 2003; Tiefer, 2000, 2001b). A Cochrane review has shown limited evidence for the use pharmacological therapy for the treatment of vaginismus (McGuire & Hawton, 2009). The pharmaceutical industry, also based on the medical model, has been criticised for reducing sexual dysfunction to a physical symptom to be medicated and cured, and for minimising the role of individual, relationship and cultural contributing factors (Tiefer, 2000).

The Focus on the Ability to have Penetrative Sex as a Measure of Success

Sex therapy models tend to focus on performance outcomes, such as the ability to tolerate penetration in the case of vaginismus, rather than emphasising sexual health and pleasure and relationship dynamics (Henderson, 2013; Pereira et al., 2013). For example, a Taiwanese study by Jeng et al. (2006) that employed Masters and Johnson's traditional model of sex therapy and consummation as a marker of success advocated "aggressive management" of the problem; this meant that the partners were encouraged to aggressively penetrate without withdrawal. In a clinical sample of one hundred women, 93% could tolerate penetration, over 63% of patients were pregnant or had given birth but only 3.3% of patients who reported having regular intercourse did so only when they felt obligated or cooperated passively and only 6.7% had experienced orgasm (Jeng et al., 2006, p. 386). Engman et al. (2010) reported that 81% of women who were treated with cognitive-behavioural therapy for vaginismus could successfully have intercourse but only 6% were able to have pain-free intercourse. This "aggressive management" to speed up intercourse by physical means alone may be an inappropriate indicator of success as, even when intercourse is achieved, some women could not consummate without pain (dyspareunia), the frequency of intercourse tended to be functional and related to childbearing (Ozdemir et al., 2008), and was not always a pleasurable experience (Binik et al., 1999). Melles et al. (2013) recommended that systematic desensitisation may be used to strengthen the association between positive affect and vaginal penetration. Even when the feelings of subjective pain can be lessened through systematic desensitisation, however there is no guarantee that patients will be able to have pleasurable intercourse as the condition involves much more than just a fear of pain or intercourse (Binik et al., 1999) and can, for example, include cognitions about sexual guilt (Canin, 2006; Ward & Ogden, 1994). For some, the desire to have children is used as a positive indicator for successful treatment outcome (J.D.M. van Lankveld et al., 2010) but

quite often intercourse ceases completely after the goal of pregnancy has been achieved (Binik et al., 1999; Drenth et al., 1996). There is little evidence that sexual pain disorders can be cured by vaginal delivery in childbirth through the stretching of the pelvic muscles and there may be an increased risk of vaginal trauma by attempting to give birth through tense muscles (T.Y. Rosenbaum & Padoa, 2012).

Even though success rates with physical or behavioural therapies are widely reported, the methodology of such studies has been questioned as success rates have been found to range from 100% to less than 60%, drop-out rates tend to be high and, in the few cases where there was long term follow up, high relapse rates were reported (Binik et al., 1999). A recent systematic review and meta-analysis of medical and psychosocial interventions for vaginismus by Maseroli et al. (2018) concluded that there was little evidence to suggest that behavioural based sex therapies were superior to other forms of therapies including physical and pharmacological. The authors also cautioned that the success of any intervention for vaginismus is questionable if the successful outcome measure is vaginal penetration rather than sexual satisfaction.

Couples do not always identify non-consummation as a difficulty if sexual alternatives are mutually satisfying and if there is a desire to have children, it can be achieved in other ways (Drenth, 1988). Kleinplatz notes that the emphasis that traditional sex therapy puts on penetration is “particularly noteworthy” when the ability of women with vaginismus to enjoy alternative sex acts to the point of orgasm is well documented in the literature (Kleinplatz, 1998, p. 54). It has also been suggested that the medicalisation of sexual pain disorders and the emphasis on penetrative vaginal sex as an outcome measure of successful treatment may be a reflection of heteronormativity (Farrell & Cacchioni, 2012). The Masters and Johnson model has been criticised for being male-centred in its definition of sexual normality because it defines sexuality in terms of physical performance (Binik, 2010). The medical model emphasises proper genital functioning rather than “assessment of education about sexual

motives, scripts, pleasure, power, emotionality, sensuality, communication or connectedness" (Tiefer, 2001a, p. 90), that is also part of the complexity of the human sexual response.

Heteronormative views also permeate the attitudes of the women themselves who seek a medicalisation of a condition that is often dismissed by physicians as being "in their heads" (Cacchioni & Wolkowitz, 2011). There is a danger that such treatments will encourage them to conform to heteronormative sexual stereotypes and perform what is perceived as "real" sex (Cacchioni & Wolkowitz, 2011; Farrell & Cacchioni, 2012). One qualitative study reported that the ability to have sex and satisfy a sexual partner was seen to be an essential affirmation of the self-concept of being a normal woman (Elmerstig et al., 2008). It has been found that women's concerns regarding their own sexual difficulties are often affected by traditional sexual scripts that prioritise the impact for their partner's sexual fulfilment but not their own (Darrouzet-Nardi & Hatch, 2014). Masters and Johnson's approach to achieving marital harmony through placing emphasis on a woman's ability to engage in penetrative sex has been criticised as traditionalist (Denman, 2004).

There are also ethical implications in treating women who do not want to be treated (Kaneko, 2001). According to Meana (2009), a core part of treatment is to educate the client about treatment options so that they can make an informed decision. Leiblum and Wiegel (2002) suggest that women may feel ambivalent about engaging in therapy for vaginismus. While they may wish to be able to engage in desired sexual activity they may also experience an increased obligation to engage in sexual encounters at the request of their partner. Some theorists nevertheless continue to prioritise penetration as a measure of success because they are concerned that changing the focus of the outcome could contribute to further avoidance behaviours (M.M. ter Kuile et al., 2007) whereas others see it as reductionist and objectifying (Kleinplatz, 1998). It is important to acknowledge, however, that understandings of sexuality are rooted in cultural contexts (Denman, 2004) and serve a variety of social functions (Fagan, 2004). The British Association for Sexual Health and HIV (BASHH) advised that, in treating

women with vaginismus, penile vaginal penetration should not be assumed by the physician as the desired outcome for the woman (Crowley et al., 2006). Leiblum and Wiegel (2002) recommend that any treatment of vaginismus should begin with the assessment of the woman's feelings and fears about being perceived both by herself and by others as a sexual being. Barnes (1986a) suggests that rather than viewing penetration as a successful outcome, the meaning of penetration in terms of the sexuality of the couple should be explored. Sexual relationships can be recast as part of a complex life narrative within a specific culture in order to give meaning to the couple's experience (Fagan, 2004).

A focus on performance outcomes can limit what sex therapists ask their clients about and inhibit the use of other approaches and models that incorporate the importance of complex experiences on sexual functioning such as the role of past conditioning, inter-personal relationships and socio-cultural contexts (Ogden & Ward, 2014). Sex therapy in the Netherlands circa 1960 changed the outcome measure for success from intercourse to emotional intimacy (M.M. ter Kuile et al., 2007). Instead of measuring successful sex therapy as perfect genital functioning and the ability to have penetrative sex, success was measured in increasing a couple's desire, excitement and intimacy (Dias-Amaral & Marques-Pinto, 2018) and the increased pleasure and happiness of the couple (Leiblum & Wiegel, 2002; Ozdemir et al., 2008; Weijmar-Schultz et al., 2005). It was advocated that success rates should be based on the feelings of both partners in the relationship and that non-coital sexual behaviour could also be encouraged in order to take the emphasis from vaginal penetration to sensual pleasures (Ng, 2001), mutually pleasurable sexual activities that may or may not include penetration (Al-Abbadey et al., 2016), and wider issues of trust and emotional safety (Ward & Ogden, 1994). Overall, the goal of sex therapy is to work out a mutually satisfactory arrangement for both partners that leads to mutual comfort, pleasure and satisfaction and increased erotic intimacy (Kleinplatz, 2003; Leiblum, 2007; Leiblum & Wiegel, 2002). As the independence of women increases in Middle Eastern societies, changes in traditional expectations have led

to couples seeking pleasure rather than just penetration as outcomes of sex therapy (Ozdemir et al., 2008). Intercourse should be envisioned as a consequence rather than the primary goal of successful therapy (Meana et al., 2017).

There may be a need to explore the meaning of the vaginismus with the women in order to explore deeper issues of self-identity. One study that treated women successfully using cognitive-behavioural therapy found that the women reported significantly higher self-worth as sexual partners, as women, and as human beings than before the treatment, and 12% were able to overcome the difficulty without medical intervention once they were given education about vaginismus (Engman et al., 2010). The researchers noted that measures of self-worth was as important a measure of a successful outcome as the ability to have intercourse.

The Medicalisation and Compartmentalisation of Sex Therapy

When Masters and Johnson's model was published in 1970, its emphasis on the direct treatment of the sexual dysfunction (in the case of vaginismus, the physical spasm) was in stark contrast to psychoanalytic therapies that emphasised the underlying interpersonal or intrapersonal difficulties that were seen to be at the root of sexual dysfunctions and treatments that targeted these difficulties (Binik & Meana, 2009). Although Singer-Kaplan (1974) included psychodynamic elements in her model of human sexuality, she specified that treatment should concentrate on modifying the immediate response rather than deeper causes, unless they presented a barrier to desensitisation techniques. The early conflation of the symptoms of sexual difficulties with underlying problems led to a lack of development of theory, research, practice and training in sex therapy and a proliferation of medical treatments for sexual dysfunctions (Kleinplatz, 2003). Kleinplatz (2003) commented that the research, education and training in the field of sex therapy had been stagnating for decades, with purely medical treatments being readily offered as the only option and new treatment techniques rarely presented. More recently, Althof (2010) suggests that sex therapy has

evolved by combining pharmacological and psychological therapies, but also conceded that there was much research needed to support the efficacy this approach. In the case of vaginismus, because it is perceived to be relatively easy to treat and to diagnose by medical methods, there has been little research interest and very few well controlled diagnostic, etiological or treatment outcome studies (Lahaie et al., 2010).

The field of sex therapy has been criticised for not having a unified underlying theory or set of practices or empirically demonstrated treatment outcomes (Binik & Meana, 2009). For example, there are no known studies that compare vaginal muscle spasm before and after treatment so there is little confirmation that these physical therapies are actually having the desired effect (Binik et al., 1999). Heiman and Meston (1997) found that there were no controlled or treatment comparison studies of vaginismus available and this may have been due to a lack of alternative treatments offered. There is also a lack of studies comparing psychological and medical interventions for sexual problems in general (R.C. Rosen & Leiblum, 1995). The results of studies employing the Masters and Johnson model tend to be inconsistent due to the lack of systematic studies and poor methodology, and there is insufficient evidence that these methods are superior in the treatment of sexual disorders (Pereira et al., 2013; J.D.M. van Lankveld et al., 2010).

Cognitive-behavioural therapy has been reported to be successful in facilitating intercourse, decreasing the fear of intercourse and reducing avoidance behaviours (M.M. ter Kuile et al., 2007). Cognitive-behavioural therapy can be included in sex therapy to target thoughts, emotions, behaviours. The first stage provides psychoeducation about the psychological factors that contribute to and maintain sexual difficulties. The second stage concentrates on reducing maladaptive coping strategies that include: catastrophising, hypervigilance to pain, avoidance and excessive anxiety, while increasing adaptive strategies such as connecting with the partner through nonsexual physical and emotional intimacy and facilitating experiences of desire arousal and sexual intimacy (Bergeron et al., 2014). A

number of studies evaluating the efficacy of cognitive-behavioural therapy in treating sexual pain disorders have found significant reductions in self-reported pain during intercourse (Bergeron et al., 2007), reductions in muscle tension and increases in sexual satisfaction (M.M. ter Kuile & Weijenborg, 2006) and improved pain-relevant coping and self-management skills and better patient satisfaction (Masheb et al., 2009).

Research that studies the efficacy of cognitive behavioural techniques for vaginismus, however, are far from consistent in their methodology and rates of success. The inconsistency of results reported could also be related to a lack of definition of what constitutes cognitive behavioural therapy. Despite research into the role of emotional and cognitive factors in sexual dysfunction, it has had little impact on actual clinical interventions (R.C. Rosen & Leiblum, 1995). Cognitive behavioural therapy for vaginismus has tended to mostly involve systematic desensitization and relaxation exercises, e.g. (Engman et al., 2010) and so there seems to be more emphasis on the behavioural rather than the cognitive (Al-Abbadey et al., 2016). Dattilio (2010) has criticised cognitive-behavioural therapy for ignoring emotional and relationship factors and suggests that a greater emphasis should be placed upon the affective and emotional aspects of relationships in therapy. At the other extreme, some studies will include many different measures simultaneously. For example, one study that reported high success rates used gradual exposure, pelvic-floor muscle relaxation techniques, sexual education and cognitive techniques and so the researchers could not determine which of the techniques had led to the successful outcome (M.M. ter Kuile et al., 2007). In addition, fewer outcome studies were being conducted and education, training, and government research funding for both male and female sexual dysfunctions were being cut in favour of those in pharmacology since the 1980s (Melnik et al., 2012; Schover & Leiblum, 1994).

Binik and Meana (2009) have argued that the specialisation of sex therapy as a distinct form of therapy may isolate the sexual problem from wider relationship issues or psychological difficulties and also from the field of psychotherapy itself, whereby a range of

theoretical understandings are considered relevant to the presentation of one clinical phenomenon. They further suggest that the exclusive application of sex therapy for the treatment of vaginismus may soon be considered akin to malpractice. Sex therapy differs from other forms of therapy, not because of the techniques it employs, but rather by the willingness of sex therapists to deal with aspects of human sexuality in therapy (Binik & Meana, 2009; Pukall, 2009). The specialisation of sex therapy may maintain societal discomfort with sexuality by marginalising it from other forms of treatment and preventing multidisciplinary approaches (Binik & Meana, 2009). Pacey (2018) suggests that an artificial divide exists between treatments offered by practitioners, with sex therapists primarily offering physical and social treatments, and psychodynamic psychotherapists offering psychological and relationship therapies. According to Timm (2009), training in sex therapy does not require training in couple issues and vice versa giving the false impression that one is separate from the other. Further, McCarthy and Thestrup (2008) state that the field of sex therapy has not kept pace with the advances in couple therapy and the artificial barriers between sex and couple therapy is detrimental to couples seeking help for sexual and intimacy difficulties.

Given the multifaceted and complex nature of sexual difficulties, multidisciplinary approaches may be superior (Anastasiadis et al., 2002; Barnes, 1986b; R.C. Rosen & Leiblum, 1995). Evidence for the effectiveness of behavioural interventions alone to treat female sexual disorders, especially the reduction in subjective anxiety is lacking, and there has been a move in recent years towards a multidisciplinary treatment model that incorporates biological and psychosocial factors (Fugl-Meyer et al., 2012; Harish et al., 2012; J.D.M. van Lankveld et al., 2010). Success rates for multidisciplinary approaches have been related to the cooperation of the multidisciplinary team members with one another during treatment (Bergeron & Lord, 2003; Ozdemir et al., 2008). When family doctors or gynaecologists work together with other professionals such as physiotherapists, sex therapists or psychotherapists, treatment options can be maximised (Fajewonyomi et al., 2007; Meana, 2009; Tulla et al.,

2006; Valins, 1988). When professionals have a basic knowledge of other health professionals' skills and are able to help their client to understand how the different treatments are integrated and complement one another, client satisfaction is increased (Bergeron & Lord, 2003). Treatment for vaginismus is most effective when it is provided by a team that can integrate the physical and emotional aspects of vaginismus into a treatment plan (Pacik, 2014a). Few research studies to date have compared multifactorial to single modality approaches in terms of efficacy for the treatment of sexual pain disorders, however, and there is a need for the provision of evidence-based treatment options for women and their partners (Bergeron et al., 2015; Simonelli et al., 2014). A systematic review by Al-Abbadey et al. (2016), however, concluded that a multidisciplinary team with active patient involvement can provide interventions that address the multifaceted nature of female sexual pain disorders and optimise treatment outcomes. Boa (2013) recommends a multidisciplinary response that focuses on the predisposing, precipitating and maintaining factors for an individualised approach to treatment. Individually or in combination, specific factors may not directly contribute to sexual difficulties, but it is important to identify potential contributing factors that might interfere with treatment options (Meana et al., 2008).

In conclusion, the literature suggests that the complexity of vaginismus cannot be effectively responded to with a homogenous approach to treatment. A multi-disciplinary response to women and their partners seeking help to overcome the physical and psychological pain associated with vaginismus is recommended.

Understanding Vaginismus from Psychosocial Perspectives

The medical model creates an artificial separation between organically based and psychogenic disorders (Segraves, 2001) and one is rarely evident without the other. The medicalisation of sexual difficulties has been criticised because it takes the emphasis off psychological components which could instead be used as an opportunity for women to

explore personal and relational difficulties (Shaw, 2001) and issues of power and gender in social relationships (Ward & Ogden, 1994). According to Ward and Ogden (1994), it is as important to explore the psychological explanations of vaginismus as the physical ones and to treat the whole person, not just the part of the body that experiences the physical spasm. One of the predictors of successful treatment for vaginismus is the attribution of the problem to psychological causes rather than physical (J.D.M. van Lankveld et al., 2010). This section explores the psychosocial understandings of the role of implicit and explicit attitudes in the vaginismic response and the sociocultural context from which these attitudes might originate.

The Role of Explicit and Implicit Attitudes in Vaginismus

Along with behavioural avoidance there is also an attitudinal component to phobic reactions to be considered. The structure of attitudes contain cognitive, affective and behavioural components (Eagly & Chaiken, 1998) and it is important to consider all of these elements in order to explain the role attitudes play in the automatic vaginismic response. The role of behavioural avoidance is incorporated into classic sex therapy models and the use of systematic desensitisation to reduce the spasm, and may consider the role of feelings such as disgust in contributing to the phobic response, but does not necessarily consider the thoughts that contribute to the reaction.

In addition to automatic associations with fear or anxiety, there are also deliberate cognitions associated with vaginismus with regard to feelings of disgust and fear (Kaneko, 2001; Reissing, 2012). Fear-based and disgust-based attributions have been linked with primary vaginismus (Reissing, 2012). Studies that employ implicit and explicit measures of disgust were able to demonstrate that women with vaginismus have unconscious automatic feelings of disgust when shown sexual stimuli but can also explicitly disclose their feelings of disgust (Borg et al., 2010a; Huijding et al., 2011). For example, women in one study reported feelings of disgust when thinking about their own genitalia, male genitalia or intercourse

(Reissing, 2012). For some women with vaginismus, feelings of disgust may further amplify existing negative and restricting sexual attitudes and motivate avoidance behaviours (Borg et al., 2010a). Avoidance behaviours can be targeted and reduced in sex therapy by employing systematic desensitisation but sex-related stimuli can retain their negative affect (Huijding et al., 2011). Women with primary vaginismus report lower levels of perceived penetration control, higher levels of catastrophic and pain cognitions, negative self-image cognitions, and genital incompatibility cognitions when compared with women with dyspareunia (Klaassen & Ter Kuile, 2009). Ward and Ogden (1994) identified such cognitions in their qualitative study with women who experienced vaginismus:

> Sex is dangerous, pregnancy is frightening, you can be damaged, childbirth is frightening, sex is painful, sex is undignified, contraception is frightening, sex is disgusting, sex is animal-like, nice girls don't, pleasure is not allowed, sex makes me feel guilty, […] sex is terrifying, […] I'm too small, I'll be ripped apart (p. 442).

A study in Ireland by Barnes (1986b) also noted the phrase "animal-like" was frequently used by women with vaginismus to describe sexual intercourse. Evoking associations of the animal like nature of intercourse has also been shown to increase disgust reactions in women with vaginismus (de Jong et al., 2009). For women with vaginismus, it may be useful to explore the underlying erotic fantasies that trigger fear and disgust reactions (Denman, 2004; Khan-Singh, 2019).

Persistent or recurrent vaginismus has been linked to disturbance of body image and sexual and gender roles for women (Fugl-Meyer et al., 2012) and a more negative sexual self-schema (Reissing et al., 2003). The attitudes toward sex described by the women in the Ward and Ogden study cited above also encompass their attitude toward themselves, their body and their sexuality, e.g. "nice girls don't," and self-esteem, e.g. "sex makes me feel guilty," and body image, "I'm too small, I'll be ripped apart" (Ward & Ogden, 1994, p. 442). "Women's sexuality encompasses sexual identity, sexual function and sexual relationships" (Graziottin,

2010, p. 254). Some women with vaginismus score much lower on measures of self-image than women diagnosed with dyspareunia (Klaassen & Ter Kuile, 2009). Vaginismus has been associated with a disturbance of body image in which the woman feels that she may not have a vaginal opening (Valins, 1988) or is "too small" (Ward & Ogden, 1994, p. 442). A woman's genitalia are anatomically hidden and are also frequently mislabelled by parents, with the vulva and clitoris being subsumed under the major category of vagina, making it difficult for girls to understand their own anatomy (Basson et al., 2000; Chodorow, 1989). Thus, sex education and treatments for sexual dysfunction should include fact-based information about the wide variation in in women's genitalia (Zielinski, 2013).

Ward and Ogden (1994) also reported low self-esteem and poor self-worth and certain attitudes towards the self, including self-dislike, guilt and helplessness. Women in their study described feeling like an abnormal and inferior woman, being separate and distanced from other people including their same-sex friends and their families and, as a consequence, not being able to confide in them. Similarly, commonly reported stress related to sexual dysfunction in Chinese women included loneliness and a lack of recognition or identity within the family (Ng, 2001). Vaginismus has also been associated with significant personal distress and difficulty in maintaining intimate relationships (Melnik et al., 2012).

The Role of Negative Sex-Related Experiences and Cognitions in Vaginismus

It is important to consider how negative sex-related cognitions originated. Some women have reported actual painful or traumatic experiences, for example, experiences of painful gynaecological examinations (Dolan, 2009; Ward & Ogden, 1994). Another study found that 87% of women who were difficult or impossible to examine had had previous negative experiences with gynaecological examinations, 79% had heightened anxiety prior to the examination and 12% reported prior sexual abuse (Huber et al., 2009). In some studies, primary vaginismus has been associated with early sexual trauma (Masters & Johnson, 1970;

Reissing et al., 2003; Silverstein, 1989) but rarely is it found to be the most significant cause (de Jong et al., 2009; J.D.M. van Lankveld et al., 2010). In Masters and Johnson's (1970) studies of vaginismus, sexual trauma was only the third most prevalent factor after a partner's sexual dysfunction and influence of religious orthodoxy. Despite being often cited as a major contributing factor, few studies have actually demonstrated the link between vaginismus and sexual trauma (de Jong et al., 2009; J.D.M. van Lankveld et al., 2010). Studies in cultures as diverse as Turkey, Iran and Ireland did not find sexual abuse to be evident in the background of any of the women presenting with primary vaginismus (Konkan et al., 2012; Mousavi-Nasab & Farnoosh, 2003; OSullivan, 1979). A qualitative survey of 89 patients rated rape and sexual abuse as bottom of the list of subjective reported reasons for vaginismus (Ward & Ogden, 1994). Conservative sexual schemas have not been reliably correlated with sexual abuse in childhood (Barnes, 1986b; Meston et al., 2006) but may provide an indirect influence by forming a negative view of sexuality (Sampson et al., 2008). Whether prior sexual abuse causes anxiety around sexuality for women is affected by many factors such as patriarchal power structures, women's position in society and the silence surrounding matters of sexuality (Ussher & Baker, 1993). The association between sexual abuse and vaginismus may exacerbate experiences of shame, which prevents women from seeking help. Research has identified that women have been hindered from going for counselling by a belief that such counselling would lead to the discovery of repressed childhood events (Ogden & Ward, 1995).

Although he initially prioritised the role of repressed early sexual abuse in producing physical symptomology, Freud later changed his mind (Meyer-Williams, 1994) and instead prioritised sexual shame and repression itself as the root cause of hysterical symptoms (Showalter, 1987). There is evidence that sexual repression and shame has a role to play in sexual dysfunction with one survey reporting that "brought up to believe sex was wrong" was the second most prevalent reason given by patients for vaginismus, after fear of pain (Ward &

Ogden, 1994). As some authors have pointed out, it is not always necessary to have direct experience of a phenomenon to experience disgust and phobic avoidance; this can also result from hearing about the negative sexual experiences of others (T.Y. Rosenbaum, 2013) and from parental attitudes and behaviours (Dolan, 2009). Reissing (2012) found that women with primary vaginismus reported fears that stemmed from what they had either heard about or read regarding pain, injury, intimacy or loss of control in the context of the sexual encounter. In 2010, The 3rd International Consultation on Sexual Medicine highlighted negative parental attitudes towards sex as one of the predictors of poor outcome for treatment (J.D.M. van Lankveld et al., 2010). A strong adherence to conservative values, strict moral related standards and an unwillingness to engage in particular sex-related behaviours was found to be correlated with vaginismus and to play an active role in the defensive reflex of the pelvic floor muscles (Borg et al., 2010a). Thus, there is a wide range of potential contributing factors to women's beliefs and assumptions about sex that may impact on both her experience of vaginismus and her experience of therapy. The findings above highlight the importance of investigating the origins of negative beliefs and attitudes towards sexual functioning considering the role of cultural attitudes, education and familial attitudes to sex and sexuality.

The Role of Culture, Education and Religious Orthodoxy in Vaginismus

The biopsychosocial model (Engel, 1977) extends the medical model to integrate physical, psychological and social components in the aetiology of sexual difficulties but the contribution of social, cultural and religious factors are the least explored (Atallah et al., 2016). Although sexuality is biological and instinctual, sexual values and the meaning of sexuality are culturally embedded (Colman, 2009; Yasan & Akdeniz, 2009). The relevance of culture is exemplified in the different prevalence rates of sexual pain disorders across different cultures. As discussed earlier in the chapter, relatively high prevalence rates are reported in Eastern cultures when compared to Western cultures and these discrepancies

prompt a wider discussion about the impact of the wider society and culture on the prevalence of vaginismus (Oberg et al., 2004).

Societies that suppress female sexuality and place a high importance on female virginity have higher incidences of sexual dysfunction including vaginismus due to a clash between intrapersonal, interpersonal and cultural sexual scripts (Ng, 2001). In cultures where fertility was the most important female attribute, female sexual pleasure was often a very low priority (APA, 2000). In cultures where sexuality is linked to intimacy, pleasure and love, sexual dysfunction is seen as detrimental to relationship and life satisfaction. In contrast, in cultures that link sexuality to marital duty and reproduction, sexual dysfunction is linked with shame and loss of social status (Atallah et al., 2016) and many religious traditions such as Catholicism, Judaism and Islam see an unconsummated marriage as grounds for divorce (Coppini, 1999). According to Meana (2009), when a woman's sexuality is tied to their socio-culturally defined sense of worth, women with vaginismus experience feelings of inadequacy and strong social pressure to comply with their partner's desires. Sexual difficulties can be influenced by early experiences which can include religious and social control over sexuality (Biswas & Ratnam, 1995; Borg et al., 2010b; Dolan, 2009; Pacik, 2011; Sampson et al., 2008; Shaw, 2001; Yasan & Akdeniz, 2009).

Difficulties in sexual relationships can reflect underlying problems in the couple relationship and can also reflect the influence of culture on the couple relationship (S. Dogan & Dogan, 2008; S. Dogan & Varol-Saracoglu, 2009; Greenstein et al., 2006; Sanchez Bravo et al., 2010). In patriarchal societies, an unconsummated marriage is seen as very shameful (Zargooshi, 2008) and an affront to masculinity (Atallah et al., 2016). Historically, a woman's femininity has been defined in heterosexual terms and those who resist sexual activity within marriage, including women experiencing vaginismus, can be stigmatised and feel pressured to satisfy their partner's sexual desires (Meana, 2009). Conservative sexual attitudes have been linked to sexual dysfunction in Middle Eastern societies (Fajewonyomi et

al., 2007; Ozdemir et al., 2008; Sampson et al., 2008; Shokrollahi et al., 1999). Higher rates of vaginismus have been identified in Middle Eastern societies compared to Western societies. These differences can be accounted for not only by differences in conservativism, e.g. expectations that brides will be virgins, religion and social structures that restrict premarital sexual relations (S. Dogan & Dogan, 2008; S. Dogan & Varol-Saracoglu, 2009; Ozdemir et al., 2008) and arranged marriages (S. Dogan & Varol-Saracoglu, 2009; Yasan & Akdeniz, 2009; Yasan & Gurgen, 2008), but also the prioritisation of male sexual and marital satisfaction over female sexual pleasure (S. Dogan, 2009). Turkish studies have identified vaginismus as the main cause of unconsummated marriage in just over 80% of couples (Ozdemir et al., 2008; Yasan & Gurgen, 2008). Despite the fact that female sexual desire problems are more common in Turkish culture than vaginismus, women are much more likely to present for treatment for vaginismus due to an inability to have intercourse (S. Dogan, 2009). Similarly, an Irish study by OSullivan (1979) found that sexual pleasure was not prioritised within the marital relationship and this influenced referrals for psychosexual problems. Women with vaginismus, as opposed to women with orgasmic difficulties, tended to come for help because the former prevented sexual intercourse and the latter did not. Vaginismus has been found to be more prevalent when husbands were uncaring, unreliable, foreplay was inadequate and intercourse was infrequent and unsensual (Fajewonyomi et al., 2007; Tugrul & Kabakci, 1997). A study in Ghana linked infrequent and unsensual sexual contact, relationship difficulties, more sexual pain and ongoing vaginismus to a fundamental lack of communication in the relationship (Amidu et al., 2010). In Turkey, lack of communication between partners was found to be a contributing factor to the lack of consummation of marriage due to vaginismus (Oniz et al., 2007). Communication difficulties between partners, including an inability to express sexual needs was also found to be a factor in Chinese populations (Ng, 2001).

Cultures that have a strong patriarchal structure and encourage the passive role of the female in sexual relationships not only have higher incidences of vaginismus but also of sexual coercion and sexual assault for females (Ng, 2001). In Nigeria, higher rates of sexual dysfunction including vaginismus have been linked to the culture of male dominance in sexual matters and the inability of women to say no to her husband if he desires intercourse because of threats of divorce and poverty, especially in the context of a polygamous marriage (Fajewonyomi et al., 2007). In Turkey, those that come from a more traditional background that prioritise male marital satisfaction often experience physical and emotional abuse from the spouse and his family and a loss of social status if she cannot consummate the marriage (Yasan et al., 2009a). In Turkey, the cultural norm of living with the husband's family after marriage is related to higher incidences of anxiety and depression for women with vaginismus (Yildirim et al., 2009). In traditional Muslim countries, the husband can withhold financial maintenance to his wife if she refuses intercourse (Mernissi, 1985).

It may not be possible to apply certain Western psychotherapeutic interventions in Eastern cultures without sufficient deference to local cultural understandings of sexual difficulties and their treatment (Ng, 1988). Sociological and religious attitudes can contribute to the development and maintenance of sexual problems and these beliefs need to be respected if the couple is to be successfully treated (Meana et al., 2008). For example, interventions may not be successful in certain cultures if they threaten traditional male gender roles (Kabakci & Batur, 2003). A study of Turkish women with vaginismus by Kabakci and Batur (2003) found that cognitive behavioural therapy was effective in improving both sexual functioning and marital harmony. Marital harmony was directly related to the reduction of blame and the acceptance of vaginismus as being a problem in the relationship rather than a problem solely due to the female partner. The researchers found, however, that therapy was not successful at improving sensuality or communication between the partners due to strict cultural barriers that prohibited this form of intimacy. Abbott et al. (2012) advise taking

cultural norms into account when approaching therapy. For example, when treating Muslim couples, respect and deference is expected to be shown to the husband as the patriarch of the family and it may not be possible for a male therapist to treat the woman without the presence of her husband or father. Abbott suggests that a strong therapeutic balance may be needed in such circumstances to strike a balance between the couple's private life and respect for their parents.

It is more common that men will view the woman as the dysfunctional partner in need of help (Hooper & Dryden, 1991). Lack of communication between partners can hinder attempts at therapeutic interventions (Oniz et al., 2007). Leiblum (2000) states that, regardless of cultural factors, prognosis tends to be very positive in couples who are motivated and in good relationships but very poor when there is conflict and lack of cooperation. High levels of anxiety in women with vaginismus have been found to be related to lack of support from partners combined with pressures to cure the disorder (Watts & Nettle, 2009). Therapeutic efforts can be hindered when the woman's sense of trust and control is undermined by her partner's sexual beliefs (Wincze, 2009). Improved communication can lead to greater relationship and sexual satisfaction (Amidu et al., 2010) and treatment programmes for vaginismus have been found to frequently improve communication between couples (Sampson et al., 2008).

Religious orthodoxy, regardless of which religion, is synonymous with guilt around sexual behaviours, which frequently leads to sexual dysfunction (Barnes, 1986b). Masters and Johnson identified religious orthodoxy as the second most influential factor in the development of vaginismus (Masters & Johnson, 1970), although Catholicism has been singled out as being particularly restrictive regarding sexual morality (Kellogg-Spadt et al., 2014). Within the four major world religions; Christianity, Judaism, Hinduism and Islam, sexual experiences prior to marriages are expressly forbidden as sinful (Kellogg-Spadt et al., 2014). Religious control over sexuality often involves the segregation of the sexes prior to

marriage (Ingles, 1998). Within Muslim cultures, communication and affection between married couples is perceived to be unnatural and society is ordered to keep them apart (Ahmed, 1993; Mernissi, 1985). In traditional Muslim societies, the partners are segregated even within marriage and social spaces are divided strictly into male and female spaces (Mernissi, 1985). In orthodox Judaism, for example Haredi communities, marriage partners are restricted from meeting frequently and meet only in the presence of a chaperone prior to marriage (Kellogg-Spadt et al., 2014). In previous generations, in Catholic countries, including Ireland, segregation of the sexes was condoned by the Catholic ethos that emphasised chastity, purity and modesty as virtues and teasing and gossip were used to socialise those who did not behave appropriately (Ingles, 1998). In most religious traditions, there is an expectation that the wedding night is designated as the moral or even required time for first intercourse. For example, in orthodox Jewish culture, sexual consummation is expected on the wedding night or shortly thereafter but restrictions are placed on any sexual experiences beforehand. If this consummation does not occur, therapeutic or religious intervention is commonplace (Ribner & Rosenbaum, 2005).

The methods of suppression used in some traditional societies can include teaching anti-sexual morality and encouraging the passive role of the female in sexual relationships (Ng, 2001). Modesty is considered to be a virtue in orthodox Jewish societies and modest dress for females is encouraged. This is at odds with mandates around sexual intercourse that dictate that the couple be completely naked and may inhibit a woman's sexual response (Ribner & Rosenbaum, 2005). Fear messages are also frequently used to discourage sexual behaviour in females. For example, in order to maintain the social norm of the virginal bride, families from Middle-Eastern cultures frequently request that the sheet placed under the bride on her wedding night be taken out and the blood shown to the family as proof of her virginity and to deter young women from pre-marital sex (Yasan et al., 2009a). This can lead young women to believe that intercourse causes unbearable pain and excessive bleeding and transmits fear,

leading to intergenerational vaginismus (S. Dogan, 2009). In traditional Muslim societies, women are taught to curb their sexual desires from an early age and are warned about the destructive effect of the penis on the vagina and uterus (Mernissi, 1985).

Studies of Western societies have also found discrepancies in the expectation of first sex among young men and women. American cultural messages around sex are much more negative for women than men, portraying sex as dangerous and for male enjoyment only (C.A. Darling & Hicks, 1982). A qualitative study in Canada revealed that young women are more likely than their male counterparts to expect and to experience pain during first attempts at intercourse (Tsui & Nicoladis, 2004). Conservative sexual attitudes that perceive sexual behaviour as immoral and wrong combined with transgression-induced disgust may be a triggering factor in the defensive reflex of the pelvic floor muscles in vaginismus (Borg et al., 2010b).

Religiosity has also been linked to a lack of sexual knowledge (Kellogg-Spadt et al., 2014) which in itself has been correlated with vaginismus in countries as diverse as Singapore, India, Turkey, South Africa, Ghana, Mexico, and Canada (Amidu et al., 2011; Biswas & Ratnam, 1995; Harish et al., 2012; Konkan et al., 2012; Oniz et al., 2007; Sampson et al., 2008; Sanchez Bravo et al., 2010; Woo & Brotto, 2008; Yasan & Akdeniz, 2009). The lack of basic knowledge of sexuality including anatomy has been demonstrated in both men and women in Muslim countries and restrictive religious practices have been found to play a role (Yasan & Akdeniz, 2009). In Turkey, sex education has been found to be virtually non-existent and knowledge of even basic anatomy can be inadequate for both partners (S. Dogan, 2009; S. Dogan & Dogan, 2008; S. Dogan & Varol-Saracoglu, 2009; Yasan & Akdeniz, 2009; Yasan et al., 2009a; Yasan et al., 2009b). For example, one Turkish study that identified vaginismus as the most common female sexual dysfunction with a 40% prevalence rate, attributed the women's sexual difficulties to a complete ignorance of sexual matters (Oniz et al., 2007). Half of the women had been told about sex by their husbands or healthcare

providers after they were married, however, due to the lack of knowledge possessed by their husbands and healthcare providers, being told had little or no beneficial effect on their understanding. Orthodox Jews have much greater restrictions on their access to education material regarding sexuality than their counterparts (Kellogg-Spadt et al., 2014). One study of vaginismus in Georgia, where the majority of the population are part of the Eastern Orthodox church, concluded that the emphasis on virginity and abstinence in religious education increased the risk of vaginismus (Marshania, 2017). In Northern Ireland, a particularly traditional and conservative form of Christian morality has been identified that replaces opportunities for informed choices regarding sexuality with conservatism and silence (Rolston et al., 2006).

The dominance of Catholicism in the Republic of Ireland has been credited with an active suppression of accurate state education in state schools (Ferriter, 2009; Ingles, 1998) which might explain the findings that Ireland has been reported as having the highest recorded clinical prevalence rates of vaginismus in Europe (Barnes, 1986a; OSullivan, 1979). The launch of the Department of Education's Relationships and Sexuality Education (RSE) curriculum in 1997 was an attempt to take control of sex education away from the Catholic Church and a move away from absolutist rules and regulations and toward empowering young people to make responsible decisions about their own sexuality (Ingles, 1998). An assessment of the RSE curriculum a decade later reported that its delivery was inconsistent and that the content was selectively addressed (Mayock et al., 2007). The report also found that respondents at government, national and regional levels, including the primary and secondary school students surveyed, stated that RSE teachers were constrained by a school ethos that was generally Catholic in orientation. Similarly, in Northern Ireland, young people have expressed high levels of dissatisfaction with the conservative moral system that underlies the provision of sex education in state schools (Rolston et al., 2006). A review of the RSE resource materials by Kiely (2005) criticised the curriculum for providing a narrow definition

of sexuality that excluded sexual pleasure and desire. A report by the Crisis Pregnancy Agency in Ireland concluded that sexual discourses that prioritise penetrative sex and non-penetrative sexual activities that centre on male pleasure need to be challenged (Hyde & Howlett, 2004). The authors suggest that alternative discourses that prioritise the sexual needs of women need to be afforded equal importance. The Joint Committee on Education and Skills Report on Relationship and Sexuality Education concluded that the RSE curriculum needs to be updated to reflect the changes that have taken place in Ireland and to provide an inclusive, holistic and empowering curriculum at an earlier age (Oireachtas, 2019). There is also a need for accountability measures to ensure that the RSE programme is fully implemented according to government policy, European standards and a human rights-based approach and to eliminate biased abstinence-only programmes from schools (Wilentz, 2016).

A report by the Crisis Pregnancy Agency of Ireland states that young girls are increasingly using media as a source of information about sex and relationships (Hyde & Howlett, 2004). Print and visual media were generally rated as positive sources of information, but the authors of the report advised that parents monitor access to media to prevent exposure to sexual material that could be age-inappropriate. Dawson et al. (2018) found that, regardless of the quality of sex education provided in Irish schools, young adults may use pornography to learn about sex. Few studies to date have examined the link between pornography use and sexual dysfunction in women (Bothe et al., 2021). Two recent surveys in North America investigated the association between pornography consumption and sexual dysfunction. Berger et al. (2019) found an association between pornography with masturbation and sexual dysfunction in males but not in females. The authors acknowledged, however, that drawing comparisons were limited by the small sample of women surveyed relative to men and the comparative lack defining features of sexual dysfunction in women. Bothe et al. (2021) reported a positive, moderate association between problematic

pornography use (in terms of being considered addictive) and sexual dysfunction in both males and females.

Better sexual knowledge has been found to be a predictor for a positive treatment outcome for vaginismus (J.D.M. van Lankveld et al., 2010). Ng (2001) recommends that education including details of sexual anatomy, physiology, psychology and sexual techniques be employed for couples with a sexual dysfunction. Along with anatomical knowledge, it is also important to teach the social, emotional, spiritual and cognitive aspects of sexuality, as well as the physical (S. Dogan, 2009) especially as these elements have been shown to be more representative of women's sexual experiences (Basson et al., 2000). Knowledge of sexuality is also linked to more frequent experience of orgasm (Shokrollahi et al., 1999). Education may also empower women to ask for help for sexual dysfunctions. Studies in Nigeria, Iran and Ireland found a higher incidence of sexual dysfunction among more highly educated women because they were much more likely to seek help, were more confident in discussing sexual problems with health professionals and with their partners and more likely to utilise every facility at their disposal than women with less education (Akhavan-Taghavi et al., 2015; Barnes, 1986a; Fajewonyomi et al., 2007). In a study by Engman et al. (2004) 12% of the women were able to resolve the vaginismus themselves and required no further treatment once they got appropriate education and practical advice regarding vaginismus from their initial sessions of cognitive-behavioural therapy. Another study found that early help seeking for vaginismus was related to increased access to information via the media and on the internet (Ozdemir et al., 2008). A recent review of self-help therapies for sexual dysfunctions concluded that cognitive-behavioural bibliotherapy, based on sensate focus and rational-emotive therapy and limited therapeutic telephone support had been successful in increasing the frequency of sexual activity and decreasing distress for women with vaginismus (J. van Lankveld, 2009). In many cases, the portrayal of sexuality on the internet often reflects constricted ideological norms (Kleinplatz, 2013), however, women who are

better educated are not only more likely to seek help but may also be able to better assess the quality of the information that they access.

In many societies, sexual repression is expected for women but is offset for men by the double standards which permit or even require premarital sexual experiences for men. As a consequence, when a girl is finally “allowed” to have a sexual relationship, i.e. within marriage, she is frequently unprepared to do so and is often sexually unresponsive due to having to constantly curb her sexual desires throughout her life (Chodorow, 1989). There is a tension between the maintenance of anti-sexual and pro-procreation scripts laid down by the family and culture and her own sexual desires. Learning about and practicing sexual intercourse helps to redefine these scripts (Ng, 2001). Therapy could also be an opportunity to explore themes of empowerment including giving women the language to ask for what they want in cultures that have not socialised them to do so (Ng, 2001) and improving communication between the sexual partners in cultures which do not encourage it (Oniz et al., 2007). Even within these cultures, when women are offered support and encouragement, they can often redefine, under their own terms, the meaning of marriage and sex which embraces their independence as well as allowing them to honour cultural expectations (Ng, 2001).

The Role of Familial Attitudes in Vaginismus

An important consideration in understanding the development of vaginismus is the role played by the family of origin. The attitude to sexuality in the family can be internalised in early childhood and contribute to the development of sexual dysfunction (Meana et al., 2008). The family is the vehicle through which cultural norms and values are socialised. According to Masters and Johnson (1970) the extent to which religious messages affect sexuality has everything to do with upbringing, with rigid, inflexible adherence to religion associated with sexual difficulties including vaginismus. While religiosity has not been shown to be directly associated with vaginismus, such women often grow up in families and cultures where

negative views of penetrative sex, pre-marital sex and sexuality in general predominate (Crowley et al., 2009). Modelling and polarisation of gender stereotypes by parents has been linked to later sexual difficulties including vaginismus (Sanchez Bravo et al., 2010). In a qualitative study, one woman commented that "it is the family relationship that affects the vaginismus rather than vice versa" (Ward & Ogden, 1994, p. 443). Family factors that had contributed to their vaginismus were identified as emotional distance, confused feelings, ridicule and inappropriate suggestions. Family dynamics dictated by certain cultural expectations of the sexuality of women may provide the conditions from which the difficulties emerge and are maintained.

A study by C.A. Darling and Hicks (1982) highlighted that daughters and sons are given very different messages about sexual activity and these differences are more likely to trigger sexual ambivalence, fear and guilt for daughters. Although pregnancy is generally portrayed in a negative light for both, only daughters are told that sex before marriage is not something that "nice" people do. In another study, both mothers and fathers were found to focus on the negative aspects of sex and sexuality and to use stark warnings about sex and promote abstinence as ways of protecting their daughter from male sexual aggression and pregnancy (DiIorio et al., 1999).

Psychoanalytic feminist theory has specifically highlighted the role of the mother in the transgenerational transmission of cultural values and agents of sexual socialisations within families (Chodorow, 1989). According to DiIorio et al. (1999) early adolescent girls are more likely to talk to their mothers than fathers about sex and, if they do, their views tend to be more conservative. Adolescents are less likely to initiate sexual intercourse if they perceive their mothers attitudes to be disapproving (Dittus & Jaccard, 2000). A qualitative study of women with vaginismus in Hong Kong identified negative attitudes from mothers towards pre-marital sex to have a more profound effect than religion for some women (Nga, 2004). Studies in Ireland found that mothers of women with vaginismus tended to portray sex and

sexuality as dirty and to dismiss sexual desire as unimportant (Barnes, 1986b). The Irish Crisis Pregnancy Agency reported that communication between mothers and daughters about sex consisted of regular and consistent warnings about the negative aspects of sex (Hyde & Howlett, 2004). More recently, Rogan (2017) concluded from her anecdotal experience working as a family doctor with psychosexual training, that Irish women with vaginismus tended to have mothers that either did not speak to their daughters about sex or were explicitly negative about sex, the motives and trustworthiness of men and pre-marital pregnancy. Mother-daughter communication has been shown to be highly effective in reducing sexual risk behaviours and preserving virginity (Hutchinson et al., 2003; Karofsky et al., 2000; McNeely et al., 2002).Three studies in America and one in Spain found a correlation between a close relationship between mother and daughter with abstinence and later first sexual activity (Dittus & Jaccard, 2000; McNeely et al., 2002; Parera & Suris, 2004; Rink et al., 2007) indicating that the relationship dynamic with the parent as well as parental attitudes may be of significance and are explored in the next section.

Understanding Vaginismus in the Context of Interpersonal Relationships

As noted above, Ng (2010) states that, in order to understand vaginismus, it must be explored at three levels; intrapersonal, interpersonal and cultural, and the interpersonal level is the one that is the least explored. This section explores the experience of vaginismus within the context of the both the family of origin and the couple relationship.

Understanding Vaginismus in the Context of Familial Relationships

Relationships within the family of origin are thought to be important factors in the development of vaginismus. Relationships between the parents of women with vaginismus are frequently poor and sometimes include abusive aspects (OSullivan, 1979; Silverstein, 1989; Ward & Ogden, 1994) but the relationship of the daughter to her parents has been

found to be more important than the parent's relationship to one another (Tugrul & Kabakci, 1997). Authoritarian, domineering, intrusive parenting has been linked to vaginismus (OSullivan, 1979; Silverstein, 1989; Tugrul & Kabakci, 1997). Some studies have identified particular unhealthy relationship patterns between father and daughter and mother and daughter.

With regard to the father-daughter relationship, an American study found that fathers of women with vaginismus tended to be moralistic, critical, threatening, overprotective and sexually seductive and did not respect the privacy or boundaries of their daughters when they were growing up (Silverstein, 1989). Irish studies identified fathers as often peripheral figures that were frightening, threatening and aggressive, often with high rates of alcoholism (Barnes, 1986b; OSullivan, 1979). According to Barnes (1986b), the mothers who were in these types of relationships were unable to support or defend their daughters in the face of the father's aggression; violence experienced in the home was also assumed to take place in the bedroom, where sexual behaviour was hidden. Non-sexual cumulative childhood trauma that can include physical or emotional abuse, neglect or exposure to inter-parental violence or bulling, has been correlated with emotional dysregulation, high emotional distress and lower sexual satisfaction and higher sexual anxiety that is sustained over time (Bigras et al., 2016). Systems of social relating can be split off from consciousness because the emotions or trauma associated with them are too overwhelming (Clulow & Fonagy, 2009). When childhood trauma cannot be processed effectively later couple relationships can be perceived as threatening or anxiety provoking (Vaillancourt-Morel et al., 2014). One Irish study found that women chose men who were kind, gentle, passive and quite often emotionally immature and completely different from their domineering fathers (OSullivan, 1979), a trend that was also found in American studies (Silverstein, 1989).

An alternative understanding of vaginismus, and one that may have its roots in the mother-daughter relationship, is the conceptualisation of vaginismus as a somatic symptom

disorder; a disorder with physical manifestations of psychological symptoms (Basson, 2011). Masters and Johnson defined vaginismus as a “classic example of psychosomatic illness” (Masters & Johnson, 1970, p. 250) and Helen Singer-Kaplan (1983) prioritised deeper intrapsychic conflicts to be the ultimate cause and that the symbolic nature of the closed vagina required further investigation. She suggested that women with vaginismus can have severe neurotic conflicts regarding sex and feel quite ambivalent about sex, pregnancy and motherhood. This perspective is compatible with psychoanalytic or psychotherapeutic approach that looks at the meanings of the symptoms for the woman (Valins, 1988) and the meaning of penetration in terms of the sexuality of the couple (Barnes, 1986a).

Vaginismus, from an object relations theory perspective, rather than concentrating on the sexual relationship as the source of difficulty, investigates the mother-daughter relationship and, in particular, the difficulty inherent for girls in separating psychologically from the mother when the mother is over-intrusive and lacks boundaries (Tugrul & Kabakci, 1997). The contribution of the mother-daughter relationship in the construction of the self is also emphasised by feminist object relations theory (Chodorow, 1989). From this perspective, from this primary emotional relationship, the child constructs an internal working model (schema) of relationships, beliefs about the availability and trustworthiness of others and their own worthiness of love (Hazan & Shaver, 1987). This in turn influences the daughter’s ability to regulate complex emotional states and social relationships throughout life (Sroufe, 2005) including sexual relationships (Clulow & Fonagy, 2009).

Mothers socialise their daughters from the beginning although, in terms of sex roles, this socialisation is mostly indirect and non-verbal (Litton Fox, 1980). For the daughter, adolescence is a time of emotional conflict between a need to retain familial closeness and the need to establish a separate identity, including a sexual identity. For the mother, it is a time of renegotiation of her role as protector of her ‘daughter-as-child’ to the role of a guide for her ‘daughter-as-woman.’ According to this theory, mothers who did not receive nurturance and

guidance from their own mothers and who have sublimated their own needs including sexual needs, are unlikely to be able to provide nurturance and guidance to their own daughters and are more likely to increase control through punishment and manipulation rather than relinquishing it during the adolescent phase. The mother experiences a need to retain control over the daughter and prevent her from becoming physically and emotionally separate (Chesler, 1997). To prevent this separation, daughters are socialised to be an archetype of femaleness modelled by their own mothers; self-sacrificing, feeling guilty for their own desires, curbing their needs and adept in the art of masking their unhappiness so as not to upset those around them (Chesler, 1997; Eichenbaum & Orbach, 1982; Elmerstig et al., 2008; L.K. Klein, 2018). According to Chodorow (1989) the socialisation of girls by their mothers from birth creates a sense of self based on the suppression of the self in order to respond to the demands of others which includes a passive sexuality and the inevitable role of childbearing, whether desired or not. Barnes (1986b) noted that, in Irish society, women with vaginismus were typically the 'good girls' of the family; obedient, unable to express anger and in constant need of approval (Barnes, 1986b; OSullivan, 1979). The heightened need for approval among women with vaginismus was also noted by Turkish and American studies (Konkan et al., 2012; Silverstein, 1989).

In psychoanalytic terms, vaginismus can be understood as an unconscious defence mechanism, a way to protect the ego, by creating a barrier to prevent merger with a controlling mother (Ward & Ogden, 1994), or a fear of intimacy which stemmed from a feeling of abandonment by the mother and the protection against future separation with an intimate other by avoiding intimacy with anyone (Arcelus & Wales, 2009). In this context, Ward and Ogden (1994) state that vaginismus can be interpreted as, "a barrier, a way of stopping people getting inside, a way of stopping pain, a way to take control; to defend against being controlled by others; to be separate; to avoid disintegration" (p.441). According to Chodorow (1989), the mother's influence can be so powerful that, even in adulthood, an

enmeshed relationship with their mother can be retained. It is argued that females who, in late adolescence, can be assertive with their mothers and establish an identity independently of their mothers are less fearful of sexual intimacy and non-sexual intimacy with their romantic partners (Thériault, 2003). The research indicates that the mother-daughter relationship is a vital component of therapy for vaginismus (Tugrul & Kabakci, 1997).

Understanding Vaginismus in the Context of the Couple Relationship

Helen Singer-Kaplan (1983) claimed that in some cases, vaginismus may be a passive-aggressive response to punish the male partner. For example, an Iranian study found that in relationships with extreme age differences and forced, loveless marriages, the woman's vaginal spasm appeared to be intentional rather than, or in addition to, the reflexive spasm (Zargooshi, 2008). This interpretation is disputed because it is unlikely that the severity of the vaginismic spasm can be produced voluntarily and so cannot consciously be used by women to avoid intercourse (Jeng 2004). Masters and Johnson prioritised the demonstration of the existence of the vaginal spasm or contraction at the beginning of their couples therapy for vaginismus because they felt it was important that both partners understand that this response is involuntary and reflexive rather than intentional (Masters & Johnson, 1970).

Regarding the role of the partner in vaginismus, Barnes (1986b) study in Ireland concluded that the partner is only sometimes found to be the cause of the disorder but always has a role in its maintenance. Meana (2009) states that difficulties in the relationship do not need to be directly responsible for a problem like vaginismus in order to be considered an important contributing factor. Few studies have examined the role of the relationship between the sexual partners in the development and maintenance of the disorder because typically only the female partner is included in these studies and this is seen as a major limitation to the understanding of vaginismus (Davis & Reissing, 2007; Oniz et al., 2007). Heiman and Meston (1997) reported that none of the studies of vaginismus they reviewed had included

couples despite the fact that, in the original Masters and Johnson trials, treatment always required both partners' involvement. They also found that when data is collected on both partners that the partners' data are inevitably underutilised for analysis. This section examines the role of the partner in the maintenance and resolution of vaginismus.

Fear of losing control or letting down defences can be intensified in intimate situations. The sexual encounter requires loss of control to facilitate orgasm and this involves allowing oneself to be vulnerable and the lowering of defences (Bancroft, 2009). During the sexual encounter, women with vaginismus report feeling a loss of control both of their own bodies and of the sexual encounter during penetration (Cherner & Reissing, 2013), fear of the disintegration of the self (Coppini, 1999) fear of physical harm, pain or even death during intercourse (Tugrul & Kabakci, 1997). Sexual intercourse is seen as an invasion or violation of the body and the spasm represents a need to defend oneself, provide boundaries and protect against violation and the disintegration of the self (Silverstein, 1989). According to Clulow and Boerma (2009) the underlying fear for couples who experience difficulties in losing themselves in the sexual encounter may be that uncontained repressed feelings may be unleashed that may be threatening to the relationship. In order to protect against this, the couple may sublimate the sexual aspects of their relationship but to avoid separation, develop an enmeshed relationship dynamic that emphasises similarities to an unrealistic level.

In contrast to the masculine stereotype that men in patriarchal cultures may strive to live up to, some men in relationships with women with vaginismus instead strive to be "good guys" (Sampson et al., 2008, p. 52) just as the woman strives to live up to the model of the "perfect little lady" (Ward & Ogden, 1994, p. 441). Both of these schemas have passivity in common, preventing women from becoming sexual adults and men from taking an active role in the sexual relationship problems. In both partners, initial experiences of guilt, shame, fear and distrust lead to frustration, anger, resentment and hostility and eventually to helplessness, hopelessness and powerlessness (Kessler, 1988). Sampson et al. (2008) has also highlighted

the impact of collusion in the relationships that helps to maintain vaginismus. Women with vaginismus may seek out men that are less dominant, sexually inexperienced and kind to reduce the threat of possible intercourse. Men may use their belief systems such as being a nice guy or family values to justify the lack of sexual intimacy and, most importantly, will not confront or challenge their partner's sexually avoidant behaviour. One study in Turkey found that half of the husbands were considerate and helpful and one-third showed no outward dissatisfaction with the lack of intercourse in their marriage (Tugrul & Kabakci, 1997). Thus, with the collusion of both partners, relationships can last for decades without sexual intercourse or without any sexual intimacy. This collusive part of the relationship is typically unconscious but can be elucidated in therapy, leading to personal and relational insight which can be catalysts for change (Butler & Joyce, 1998). Some theorists have suggested that the male partners' reluctance to deal with non-consummation may be a conscious or unconscious strategy to hide their own sexual difficulties, e.g. erectile dysfunction, (S. Dogan & Dogan, 2008; Masters & Johnson, 1970) but other studies have not found this to be the case (Sampson et al., 2008; Tugrul & Kabakci, 1997). Conversely, one study of male partners found that commitment to sex therapy and support for female partners was actually enhanced in some cases when the partners placed importance on being a "good guy" (Sampson et al., 2008).

To date, research regarding dyadic factors, including interpersonal relating and responding, in the development and maintenance of vaginismus has been very sparse and results are inconclusive due to inconsistent methodologies (Davis & Reissing, 2007). When studies do include the male partner a wide variety of personalities, relationship dynamics and coping styles are evident (Sampson et al., 2008). Some studies have found that, in comparison to other sexual difficulties, couples experiencing vaginismus tend to have better relationships, less psychopathology and higher motivation for treatment and for doing the homework assigned in sex therapies (Hawton & Catalan, 1990; J.D.M. van Lankveld et al., 2010).

Although some couples have a profound lack of sexual knowledge, others tend to have a wider non-coital sexual repertoire that can quite often be enough to keep both partners sexually satisfied (Sampson et al., 2008). Interestingly, in a number of studies, the quality of the relationship and relationship satisfaction tends to be unaffected by the ability to have full intercourse whether due to male sexual dysfunction (Bodenmann et al., 2006) or female sexual dysfunction (Hawton & Catalan, 1990) but in some cases the quality of the relationship has been found to be a predictor of vaginismus (Bodenmann et al., 2006). Situational vaginismus can be a manifestation of relationship difficulties (APA, 2013). Therefore, unresolved relationship problems could be addressed in couple therapy prior to treating vaginismus (Leiblum, 2007). In these cases, it may be beneficial to analyse the role of stressful relationships in maintaining and creating sexual dysfunction and to concentrate on reducing stress within the relationship by focusing on dyadic coping, mutuality, fairness and respect. In some cases, teaching stress management techniques have been found to be beneficial for couples with sexual difficulties, including vaginismus (Bodenmann et al., 2006). In other cases, general stress management techniques such as relaxation training has been found to be of limited use and focusing stress management skills within the couple relationship designed to improve communication and conflict resolution has been found to be more successful (Bodenmann et al., 2006). Barnes (1986a) concluded that, in cases of primary vaginismus, the stress on both partners need to be acknowledged and that the inclusion of the partner in sex therapy was necessary for a successful long-term outcome. Many couples have not spoken to anybody, even each other, about sexual problems within the relationship (Tiefer, 2001b). For sex therapy to be successful, the involvement of the partner appears to be crucial (R.C. Rosen & Leiblum, 1995). Involvement of the partner in physical and cognitive-behavioural therapies affords the opportunity to understand the location of and reasons for the pain, to feel the muscle spasm, to understand his role in contributing to the problem and to provide and receive positive feedback and emotional support (Bergeron & Lord, 2003).

Understanding Vaginismus in the Irish Context: Previous Studies

To date, only two known studies have examined the aetiology of vaginismus in Ireland, one by OSullivan (1979) and one by Barnes (1986b). As discussed above, the high rate of referrals for vaginismus (42%) reported in 1979 was found to have been related to a combination of factors unique to Irish culture at that time, which included negative sexual conditioning that involved religious themes related to ultra-conservative orthodox Catholicism (OSullivan, 1979). O'Sullivan noted that, in contrast with the rest of Europe, Ireland has very strong taboos around sex with extremely conservative attitudes regarding intercourse outside of marriage, divorce, contraception or any expression of sexual feelings. These messages that linked sexuality and sexual behaviours with guilt and frequently led to sexual difficulties were found to be transmitted through the family. Another key factor was an authoritarian parenting style and strict monitoring of the sexual behaviour of daughters. Sexual pleasure was not prioritised within the marital relationship.

Barnes (1986a) also conducted a study of vaginismus at an Irish psychosexual clinic between 1978-1983 and estimated that vaginismus was a concern for five out of every thousand marriages in Ireland. Three-quarters of those who attended lived close to the capital and so the rural population was under-represented in this sample. The couples that came from rural areas had a lower rate of successful outcomes and Barnes speculated that there was a higher incidence of vaginismus in rural populations due to lower provisions of local services. It is interesting to note that whether these Irish women were found to have had convent education or not, the primary source of morality was always found to be the home (Barnes, 1986b). This finding supports the feminist theories of Chodorow (1989) that located gender oppression not in the public and social realm, but in the family. The parent-child relationship was regarded to be of primary importance in the Irish studies. Parents used religious and moral values to induce guilt and shame regarding sexual matters. In 19% of cases, Barnes

found high levels of religious standards in the home, enforced by both parents, contributed to sexual anxiety and a code of behaviour that did not allow for the gradual development of responsibility for sexual relationships. In 15% of the cases there was negative conditioning by mothers which was described as "usually gentle and well-intentioned, but undoubtedly manipulative of attitudes and relationships so that the level of control achieved was near complete" (Barnes, 1986b, p. 63). Sexuality was dismissed as unimportant by their mothers and in two of the cases the conditioning was more overt, explicitly stating that genital regions were unclean and sex was animal-like. Barnes concluded that strong parochial religiosity is intensified within the family and enforced by the mother. The majority of women subjected to this type of conditioning who developed vaginismus also showed a very strong identification with their mothers, developing an asexual or anti-sexual identity that later conflicted with their new identity within the marital relationship. Barnes concluded that Irish society was distinctly different from other Western cultures and growing up in Irish families uniquely contributed to higher rates of vaginismus than the rest of Europe. This conditioning appears to have been more intense in rural rather than urban areas which could also account for the higher success rates found among women in the study who were living within the greater Dublin area.

Inglis has described the Irish population as being "sexually unique" in comparison with other Western societies with the lowest levels of marriage, the highest level of bachelors and spinsters, and the highest level of marital fertility (Inglis, 2005). Inglis states that the Catholic Church was instrumental in constructing a sexually repressed society but it was enforced in the home (mainly by mothers) and in Catholic run schools. It is worth acknowledging, however, that there is some recent evidence that Irish attitudes to sexual pleasure and procreation are gradually changing. A report on trends in mass sexual behaviour and attitudes towards sex conducted in 15 member states of the European Union that included Ireland stated that there is evidence of increasing sexual liberalisation (Compston, 2006). The report

noted a general trend of earlier first sex, more partners, more varied sexual positions and technique, premarital sex and cohabitation. A study of university students by Malesevic (2003) found that Irish values about sex and sexuality are no longer predominantly conservative and are spread across an egalitarian, open-minded to conservative spectrum.

Inglis (2005), although acknowledging that Ireland is undergoing a sexual and moral revolution, stated the legacy of Catholic morality on which Ireland was founded still has a certain amount of influence over sex and sexuality. He referenced, for example, the persistence of the double standard with regard to female sexuality and the negative stigma regarding women considered to be sexually transgressive. The publication of the Murphy and Ryan reports in 2009, however, revealed the scale of sexual abuse in Roman Catholic religious institutions and questioned their authority regarding sexuality and sexual rights more broadly (Wilentz, 2016). A report by the Royal College of Surgeons in Ireland revealed that 77% of the general public surveyed were critical of the Catholic Church's handling of the report's sex abuse scandals and 58% did not have faith in their ability to protect children entrusted to their care . The Republic of Ireland has undergone significant attitude change regarding sexual and reproductive health as evidenced by the national referendum that passed the Marriage Equality Act, to allow same-sex marriage, and the passing of the Gender Recognition Act, to officially recognise change of gender, both in 2015 (Wilentz, 2016). A report by the Crisis Pregnancy Agency of Ireland stated that over the past forty years, there has been a dramatic decline in impact of the Catholic Church on attitudes to sexuality (Hyde & Howlett, 2004). The authors reported that, even among religious students, socio-cultural factors had more influence on their attitudes to sexuality and sexual behaviour.

Understanding Vaginismus in the Irish Context: The Current Study

Inglis has suggested that, given the exceptional history of Ireland in comparison with Western societies, the general lack of interest in researching sexuality in Irish academia as puzzling (Inglis, 2005). He suggests that a persistence of sexual shame prevents academics from talking or writing about sexual practices, feelings or emotions. Despite having the highest recorded rate of vaginismus in Europe, it is now almost forty years since studies of vaginismus were conducted in Ireland, and no new data regarding the experience of vaginismus has been gathered since. No current statistics exist for the Republic of Ireland but, as noted above, a quantitative survey in Northern Ireland concluded that vaginismus was the second most prevalent concern after lack of sexual desire (Roy, 2002). At this time, there is no current data regarding the reasons for the occurrence of vaginismus in modern day Ireland. Overall, very little is known about the psychosocial risk factors and meaning of the experience of vaginismus for Irish women. Only a handful of studies have looked at the topic qualitatively and only two in Ireland (Barnes, 1986a; OSullivan, 1979). There is, therefore, a need to explore the factors specific to Irish culture that contribute to the development of vaginismus.

Research into sexual pain disorders has generally tended to include only the female partner and misses the opportunity to examine the role of dynamic interpersonal processes in sexual dysfunction (Bergeron et al., 2015). Few of the studies to date have looked at the experience of vaginismus from the point of view of both partners in the relationship. One qualitative study by Sampson et al. (2008) that did include both partners found that the reaction of the male partner to the experience vaginismus in the relationship was related to factors such as self-concept and cultural expectations of masculinity. There are very few studies of vaginismus that have included data from both partners. The co-construction of the meaning of vaginismus within the context of the relationship has yet to be investigated and

may prove useful in its resolution. For example, Meana (2009) suggests shifting the couples' perception of vaginismus from the woman's problem to a couple problem is the first important therapeutic intervention. Furthermore, investigations of ex-sufferers may shed some light on the resolution of the condition (Ward & Ogden, 1994) in terms of identifying coping mechanisms and resilience of the individual and the couple in understanding, dealing with and resolving the problem.

Few studies have looked at the experience of couples' attempts at help-seeking for vaginismus. An Iranian survey of sexual dysfunction and help-seeking behaviours found that women were often ashamed to speak about the problem and complained that they were not asked routinely about their sex life during doctor's visits (Vahdaninia et al., 2009). Those who did speak about it said that a definite diagnosis and treatment plan was given in only 61% and 57% of cases respectively. The authors concluded that doctors often do not feel qualified to treat sexual dysfunctions and more education was needed for both doctors and patients. A British national probability sample survey concluded that few people sought help with their problems and that help seeking was related to the availability of advice and treatment, with family doctors often according sexual dysfunction a low priority (Mercer et al., 2003). One postal questionnaire in Britain sent to 67 women experiencing vaginismus and 22 women who had overcome the difficulty and found that, overall, getting help was rated as very difficult (Ogden & Ward, 1995). Help-seeking experiences have not been recently investigated and so little is known about the help-seeking experiences of couples in modern day Ireland for whom vaginismus is a concern.

Despite its universal prevalence, vaginismus remains under-researched (Watts & Nettle, 2009). The overall aim of the current research study is to build a conceptual model of vaginismus within an Irish context that can provide a greater understanding of the contributing factors and experiences of women and couples and how they attempt to cope with and seek help for vaginismus. This study not only includes the perspective of both

partners on their experiences of vaginismus but also includes the perspectives of a wide variety of health care professionals who work with individuals and couples with vaginismus. The ultimate objective of generating a theory of vaginismus is that it may have a beneficial impact for individuals, couples, psychosexual therapists, clinical supervisors and medical practitioners that may lead to greater understanding of the difficulty and enhanced responses by health care professionals.

Chapter Three: Methodology

The most important considerations when deciding on the methodology and methods to be used in a particular study are; firstly, the research question and secondly, epistemological considerations (Trauth, 2001). This chapter, therefore, outlines how the research question and epistemological considerations informed the methodological decisions, the choice of method, procedure, analysis and the ethical considerations throughout the research study. The decisions that led the researcher ultimately to choose a qualitative grounded theory methodology situated in the Straussian tradition employing semi-structured interviewing methods for this particular study are discussed. The procedures used in conducting the study are presented along with an evaluation of the methodological rigour of the study.

Choosing Qualitative Research

Qualitative research is "any type of research that produces findings not arrived at by statistical procedures or other means of quantification" (Strauss & Corbin, 1998, p. 17). Approaches rooted in the quantitative (positivist) tradition seek to study a fundamental reality beyond experience (Smith, 2008). Qualitative research's philosophical roots lie in Husserlian phenomenology that privileges experience as the focus of enquiry (Smith, 2008). Qualitative research is concerned with understanding experiences and how people make sense of their experiences in order to understand the implications and consequences of the experiences (Willig, 2012).

The research question should be the most important influence for choosing a methodological framework (Trauth, 2001). Qualitative research lends itself to answering questions that concern human experience. For example, Strauss and Corbin (1998, p. 38) define the research question most suitable for a grounded theory study as "a statement that identifies the phenomenon to be studied" and "tend to be oriented toward action and process." In the case of this particular study, the research question specifies vaginismus as the

phenomenon to be studied and the action and process of concern are both the experiences of Irish couples with vaginismus and help seeking, and the experiences of professionals providing help. Qualitative-oriented research allows for an exploration of these research questions in a way that could not be facilitated by more quantitative-oriented research methods because an in-depth exploration of experience is privileged as the focus of enquiry rather than an objective, external reality (Smith, 2008).

Qualitative methodologies are useful when theories are not available, when it is difficult to identify variables, and when there is a need to explain and present a detailed account of the topic in a particular setting (Creswell, 2013) because they seek to generate theory rather than to test existing theories (Bryman, 2004). The exploratory nature of the research being undertaken for this particular study is therefore better facilitated by qualitative methodologies. Understanding the experiences of couples in Ireland who are experiencing or have experienced vaginismus and their experiences of seeking help in Ireland is an unknown phenomenon that needs further exploration. As can be seen from the previous chapter, there is a sparsity of literature on experiences of vaginismus in Ireland. Therefore, a study of the experience of vaginismus in the Irish context would benefit from the qualitative approach designed to generate a theory of an underexplored phenomenon.

The overall aim of the research study is to build a theoretical model of vaginismus within an Irish context that can provide a greater understanding of the contributing factors and experiences of women and couples and how they attempt to cope with and seek help for vaginismus. A theory of vaginismus developed by this study, situated as it is in a specific context, would be classed as a middle-range theory because it falls between working hypotheses that people use in everyday life and all-inclusive grand theories (Glaser & Strauss, 1967) and seeks to understand and explain an aspect of social life (Bryman, 2004). One of the advantages of producing a middle-range or substantive theory is that it relates to a specific context rather than being abstract and so is readily understandable by researchers and lay

people (Glaser & Strauss, 1967). Grounded theory allows the researcher to progress from a description of a phenomenon to a theory of the process by which it is happening (Strauss & Corbin, 1998), which achieves the aim of generating a substantive theory (Cooney, 2010).

The substantive theory developed must not only represent the substantive area to which it is applied but also be sufficiently general to be applicable to a diverse range of situations within the substantive area (Glaser & Strauss, 1967). The development of a theory can be strengthened using the process of triangulation by comparing existing representations of a phenomenon, the social distribution of representations across social groups and the development of existing representations (Willig & Stainton-Rogers, 2008). In the case of this particular study, the existing representation of the phenomenon of vaginismus comes from the available literature on the topic. Social groups are distinguished from one another with regard to differences in their knowledge and experience (Willig & Stainton-Rogers, 2008) and, in the case of this particular study, the knowledge and direct experience of vaginismus in the context of the couple relationship is compared with the knowledge and experience of professionals who work with individuals and couples experiencing vaginismus. As outlined in the literature review, there are a myriad of existing representations of vaginismus from different theoretical perspectives, but none that have developed from an exploration of both professional participant and couple participant data, nor are they specific to the Irish context. The aim of this present study is to generate a theory that seeks to fill this gap.

The research questions in this study have the potential to be answered by a range of methodologies situated within the qualitative tradition. For example, narrative analysis, which attempts to use a narrative framework to organise life events into a logical sequence in order to understand causal links between them (Murray, 2008) could be utilised to understand vaginismus as a developmental sequence. Discourse analysis could be used to focus on how the language used by professional and couple participants to describe vaginismus constructs their psychosocial reality of their direct and indirect experiences of the phenomenon (Willig,

2008). Interpretative phenomenological analysis could explore in depth the meanings that particular experiences, such as vaginismus, holds for participants (Smith & Osborn, 2008). However, before the meaning and language and sequential nature of a phenomenon can be studied in depth, the phenomenon itself needs to be understood. Grounded theory allows the researcher to go beyond describing phenomena to explain the processes and contexts that underlie them (Corbin & Strauss, 2015). Grounded theory methodology, similar to other qualitative methodologies, employs the constant comparative method in order to generate complex theory that is grounded closely in participant data and allows for the integration of multiple perspectives within specific contexts (Glaser & Strauss, 1967). As outlined in the literature, multiple theories of vaginismus exist within different theoretical perspectives but none have been developed from the integration of experiences of couples and professionals and within a particular socio-cultural context. Therefore, grounded theory methodology is seen to be the best fit in the case of this particular research to address the research questions and aims of the study. Ontological and epistemological considerations ultimately led to the conclusion that the Straussian version of grounded theory was the most appropriate methodology for this particular study, and these considerations are outlined below.

Choosing Grounded Theory Methodology: Ontological & Epistemological Considerations

The nuances between quantitative and qualitative approaches concern more than whether or not they use quantification or not but how they differ with respect to their ontological and epistemological orientations (Bryman, 2004). Ontology is "[t]he branch of philosophy concerned with existence and the nature of those things that exist" (Williams & May, 1996, p. 200). The ontological debate ranges from two polar positions: objectivism that sees social phenomena as real and separate from the perception of the individual and constructivism that asserts that social phenomenon and their meanings are socially

constructed by the individual (Bryman, 2004). Positivist methodologies have an underlying realist ontology, i.e. that reality exists independently of perception (Willig & Stainton-Rogers, 2008) and direct and certain knowledge of the world can be known (Hammersley, 1991). Interpretivism is a term given to a contrasting philosophy that is critical of the use of scientific models to study and explain social worlds (Bryman, 2004). Interpretivism, in contrast to positivism, has an underlying relativist ontology (Charmaz, 2003) that sees social reality as a constantly changing phenomenon constructed by individuals (Bryman, 2004; Willig & Stainton-Rogers, 2008). The interpretivist researcher seeks to understand how individuals make sense of their world without imposing his/her preconceptions (Bryman, 2004). The critical (or subtle) realist position stands in the middle of the two and posits that there is a reality independent of perception and although knowledge of them is never certain, knowledge claims can be judged with reasonable accuracy (Hammersley, 1991).

"Epistemology […] is the study of how cognitive subjects come to know the truth about given phenomena in reality" (Bodenreider et al., 2004, p. 185). The epistemological debate considers, on one side empirical knowledge under constant sceptical questioning, and on the other doubts that anything can ever be known (Hughes & Sharrock, 1997). Locating oneself within a particular epistemology is the next most important influence on the choice of research methodology after the research question (Trauth, 2001) and epistemological reflexivity, the way a study identifies its epistemological stance, should be the most important criterion for its evaluation (Willig, 2012). There are three distinct branches of grounded theory methodology, each with their own ontological and epistemological stance that will be discussed and compared in turn in order to situate this study within the larger ontological and epistemological debate and to justify the ultimate decision to utilise the Straussian version of grounded theory methodology.

Philosophical Roots of Grounded Theory

The three versions of grounded theory are: Classic Grounded Theory, which is associated most closely with the work of Barney Glaser, Straussian Grounded Theory, which was developed by Anselm Strauss and his colleague Juliet Corbin, and Social Constructivist Grounded Theory, developed by Kathy Charmaz. Although the approaches have much in common, they differ in their philosophical underpinnings, and ontological and epistemological leanings.

The ontological, epistemological and methodological philosophical roots of Glaser and Strauss' approach to grounded theory is consistent with the philosophy of Charles Sanders Peirce, known as the father of pragmatism (Nathaniel, 2011). Although Pierce's philosophical writings are based in a realist ontology that asserts that there is a truth that can be uncovered with the use of the scientific method, he does not sufficiently define the nature of truth or whether a scientific method can be agreed upon to uncover it (Haack & Kolenda, 1977). Pierce's ontological position is, therefore, more of a critical realist than a naïve realist position. Although it accepts that there is a truth to be uncovered, this truth may need to be interpreted through the lens of underlying conditions that inform behaviours and experiences (Willig, 2012). Pragmatism encourages an interpretation of the data rather than an objective and descriptive reporting of events (Charmaz, 2006). The epistemology of both pragmatism and grounded theory are similar in that they propose that the objective world can be understood through the interpretation of symbols, and that reality can be known through use of a self-correcting scientific process that uses induction, deduction and abduction as a way of discovering new knowledge (Nathaniel, 2011).

The Ontology and Epistemology of Classic Grounded Theory

The original version of grounded theory was developed by Glaser and Strauss, and they outlined their procedures for undertaking qualitative research using grounded theory

methodology in a seminal book entitled *The Discovery of Grounded Theory* (Glaser & Strauss, 1967). Instead of explaining a phenomenon through imposing existing theoretical frameworks, grounded theory allows the data collected to be the starting point for the development of a new theory (Glaser & Strauss, 1967). The epistemology of Classic Grounded Theory balances empirical and conceptual knowledge through an iterative process of data collection and analysis (Frost, 2011). The process begins with induction in which inferences are made about a small number of cases and then generalised through the process of constant comparison. Once a theory begins to emerge through joining related cases together to form theories (abduction), gaps in the data will emerge. Finally, through deductive reasoning, the theorist will make inferences about the proper direction of subsequent data gathering and the iterative and self-corrective process resumes again with new data and moves towards the truth, which is considered to be a singular, knowable truth (Nathaniel, 2011).

Glaser and Strauss ultimately disagreed on the future development of a grounded theory methodology and, it has been suggested, one of the reasons for this difference in their approaches may have been due to the differences in their ontological and epistemological leanings (Hunter et al., 2011). Glaser was influenced by his positivist training and imbued his writings with language that was more consistent with quantitative methods. Ontologically, Glaser has been described as a realist who seeks to investigate social phenomenon as an objective external reality (Charmaz, 2003). Adopting a realist position ignores the way the researcher interprets findings and assumes that what is reported is a true and faithful interpretation of knowable and independent reality (McCallin et al., 2011). A realist version of the grounded theory method assumes that the categories generated have the capacity to represent the reality of the phenomenon of interest (Willig, 2001). Positivists assume that the researcher can discover an objective reality without influencing the data and without the need to impose the analyst's own conceptual categorisations (Bryant, 2002). For a realist

researcher, reflexivity can be a way of acknowledging and striving to bracket off personal expectations and assumptions so that they do not make their way into the analysis and distort or even silence the participant's voice that is trying to make itself heard (Willig, 2012). Although some researchers doubt that this level of bracketing is possible others state that the mere awareness of the principle of bracketing makes it possible (Gubrium & Holstein, 2003).

The Ontology and Epistemology of Straussian Grounded Theory

Strauss' version of grounded theory in collaboration with Juliet Corbin represents a move toward social constructivist ontology (Cooney, 2010), which can be classed ontologically as a critical realist position (Kenny & Fourie, 2015). The critical realist position stands ontologically between realism and relativism and posits that knowledge approximates reality (Hammersley, 1991). Strauss's ontological position emphasised the symbolic interactionist roots of grounded theory that instead concentrate on the construction of meaning through interaction (Frost, 2011). The pragmatist movement that inspired symbolic interactionism is, "a theoretical perspective that assumes society, reality and self are constructed through interaction and thus rely on language and communication […] interaction is inherently dynamic and interpretive and addresses how people create, enact, and change meanings and actions" (Charmaz, 2006, p. 7). Symbolic interactionism began as an interpretation of Pierce's writings by William James that influenced the pragmatist writings of John Dewey and Herbert Mead (Nathaniel, 2011). These writings were major influences on the development of the philosophy of the Chicago School that ultimately influenced Strauss to utilise these philosophic principles to tackle certain sociological problems (Strauss, 1993). According to symbolic interactionists, the actions of any individual are based upon the interpreted meanings of his/her interaction with others (Bryman, 2004). For Strauss, there is no divide between the external and interior world. Actions are meaningful, emotional, temporal, reflexive and embedded in interactions and social worlds that can influence their

meanings, symbology and future interactions and reflections (Strauss, 1993). Symbolic interactionism underpins Strauss and Corbin's version of grounded theory but is just one possible sensitising framework among many in classic grounded theory (Nathaniel, 2011). This ontological difference is one of the key differences between Glaser and Strauss' versions of grounded theory, which became known as Classic Grounded Theory and Straussian Grounded Theory that uses different methods of analysis based on their ontological perspectives (Martin & Gynnild, 2011).

The Ontology and Epistemology of Social Constructivist Grounded Theory

Whereas Classic Grounded Theory has an objective, positivist ontological position that posits the existence of an external and discernible reality, and Straussian Grounded Theory takes a critical realist position, Charmaz' method privileges a more constructivist ontology, which allows for multiple realities. Following on from the Straussian tradition, Kathy Charmaz (2009) states that her social constructivist version of grounded theory can bridge the gap between positivistic and interpretive traditions as it uses both systematic techniques and also looks at how people construct meaning. Interpretive research is defined by a particular epistemology that recognises that knowledge is filtered through social constructions and aims to understand the social context of phenomenon (Rowlands, 2005). Charmaz argues that grounded theories should be situated in social, historical, local and interactional contexts (Charmaz, 2006)

The social constructivist position has a relativist ontology (Willig, 2012). Relativism leads to the conclusion that nothing can ever be known absolutely, and that there are multiple realities, none having precedence over another in terms of claims to represent truths about social phenomena (McCallin et al., 2011). Charmaz distinguishes her version of grounded theory from that of Glaser or Strauss by stating that rather than discovering objective data, the researcher is already part of the world and the data that is collected and that grounded theories

are constructed through interactions with other people, which includes the researcher (Charmaz, 2006).

Comparing Grounded Theory Methods

The ontological and epistemological differences between the approaches also inform differences in their procedure and methods. Glaser has been criticised not only for his lack of clarity about what research paradigm Classic Grounded Theory fits into (Kenny & Fourie, 2015) but also for being inconsistent, in espousing an objectivist, positivist ontological stance yet employing an interpretivist coding procedure (Bryant, 2002). While Glaser is adamant that grounded theory methodology should not be altered (Cooney, 2010), Strauss and Corbin reconfigured grounded theory with a rigourous coding structure that is designed to create rather than to discover a theory that is grounded in the data (Strauss & Corbin, 1998), which reflects the ontological move away from realism and towards social constructionism (Cooney, 2010). Charmaz, in her socially constructivist version of grounded theory disagrees with Glaser that theory emerges from constant comparisons of the data in an automatic fashion. She sees data, analysis and theory as socially constructed from shared experiences and relationships with participants and other sources of data. According to Charmaz, the theory produced is not in spite of the researcher's view but instead depends upon it (Charmaz, 2006). Charmaz' version of grounded theory seeks to construct a conceptual interpretation of the phenomenon in question (Charmaz, 2006).

While Glaser holds steadfast to his resolve that theory 'emerges' from the data, Strauss and Corbin see the theory as something that the researcher and participants create together and they also acknowledge the influence of macrosocial factors (Cooney, 2010). In other words, reality is not discovered, it is interpreted in multiple ways, linked to a particular time and place and influenced by environmental and contextual factors (Strauss & Corbin, 1998). Where Glaser sees reflexivity as a way of acknowledging and bracketing off personal

expectations, Strauss may encourage the use of reflexivity in order to draw on his/her own thoughts and feelings about what the participant is saying to uncover meanings within it that are not immediately obvious to the participants (Willig, 2012). For Charmaz, reflexivity involves an acknowledgement of the role of the experiences of researcher in the process of interpretation (Charmaz, 2006). With regard to method, within the symbolic interactionist epistemological stance, interviews are viewed as knowledge generation in which participants are encouraged to tell stories from their perspective and meanings are interpreted by the researcher (Frost, 2011). There is a triple layer of interpretation involved in the research as the researcher provides interpretations of their participants' interpretations and then further interprets them in terms of the concepts, theories and literature of a particular discipline (Bryman, 2004).

Both Glaser and Charmaz criticise the Straussian version of grounded theory for its rigid and overly complicated rules of coding that force the data into preconceived categories in order to form a theory from the data (Kenny & Fourie, 2015). However, Corbin and Strauss emphasise that their guidelines should be applied flexibly (Corbin & Strauss, 2015) and this concession is not acknowledged by either Glaser or Charmaz' criticisms (Kenny & Fourie, 2015). Over time, as Corbin published versions of grounded theory after Strauss' death in 1996, her versions became increasingly flexible with regard to the coding procedure and moved increasingly toward a more constructivist version of grounded theory (Kenny & Fourie, 2015).

Choosing Straussian Grounded Theory

This study aims to build a theory of vaginismus within the Irish context. The Straussian version of grounded theory was chosen for a number of reasons: (1) ability to answer the research question (2) epistemological compatibility (3) analytic strategies and (4) applicability.

Firstly, versions of grounded theory with social constructivist underpinnings are more suited to addressing the research questions. For this study, the two key research questions are: How do Irish couples experience vaginismus and seeking help? How do professionals view and work with vaginismus? Grounded theory allows the researcher to progress from a description of a phenomenon to a theory of the process by which it is happening (Strauss & Corbin, 1998), in other words, to answer questions that are interested in "how" participants respond to phenomena. Therefore, the social constructivist versions of grounded theory are more suitable to answering the research question in this study than Classic Grounded Theory.

The second consideration in choosing a methodological framework should be epistemological considerations. Strauss & Corbin's move towards a constructivist ontology reflects not only an epistemological shift in contemporary thinking (Cooney, 2010), but also acknowledges that analysis involves layers of interpretation as the researcher provides interpretations of their participants' interpretations and then further interprets them in terms of the concepts, theories and literature of a particular discipline (Bryman, 2004). Both Strauss & Corbin's and Charmaz' versions of grounded theory allow for the incorporation of environmental and contextual factors (macro conditions) that influence the phenomenon of interest (Charmaz, 2006; Strauss & Corbin, 1998). The coding procedure allows for not only the description of the experience from the perspective of participants and an explanation of the processes involved but also to situate the study in a particular sociocultural context, in this case Ireland, in order to create a substantive theory. Charmaz' social constructivist version of grounded theory, however, places the researcher's interpretation as the central conceptual interpretation, whereas the Straussian version sees this interpretation as one of many possible interpretations of the phenomenon and allows for the interpretation of the participants and the researcher and the literature to be combined into a substantive theory of vaginismus in the Irish context. The aim of the study is to build a theory of vaginismus from the perspective of couples and professionals who work with women and couples experiencing vaginismus. The

Straussian version of grounded theory is seen as a better fit to accomplish the aims of the study than the Charmazian version.

A third consideration is a practical one. As previously discussed, both Glaser and Charmaz somewhat unfairly criticise Straussian coding procedures as being prescriptive and rigid. While it is acknowledged that it is important for the integrity of the study to be consistent in the use of the methodological approach, Straussian grounded theory allows for creativity and flexibility (Kenny & Fourie, 2015) within the context of the particular research study (Strauss & Corbin, 1998). Therefore, it is possible for the novice researcher to both benefit from the structured approach of the Straussian version grounded theory and the ability to apply these coding procedures flexibly (McElvaney, 2019).

A fourth consideration has to do with the pragmatic underpinnings of Straussian grounded theory. If a theory is to be applicable to real life situations and bring about real change the findings should provide understandings of both specific and diverse populations and situations (Corbin & Strauss, 2015). This research study not only seeks to build a theory of vaginismus within the context of Irish culture but to use that theory to raise awareness and understanding and to reduce the stigma of a sexual difficulty that is all too often hidden because of feelings of shame. The pragmatist philosophy of Straussian grounded theory includes a sense of social responsibility not just to generate theory but to use it to benefit participants. The ultimate objective of generating a theory of vaginismus is that it may provide a greater understanding of vaginismus for individuals, couples and health care providers and more sensitive responses by health care professionals.

Ethical Considerations

Prior to designing any research study, ethical considerations need to be taken into account. Ethics combines "the duties and responsibilities of individuals […] with broader systems of moral principles and rules of conduct" (Denscombe, 2002, p. 175). To ensure

ethical conduct in design, recruitment and data collection procedures, it is important to undergo an ethical review prior to embarking on the study (Walton, 2016) and it is the responsibility of the researcher to follow the procedures that have been approved by an ethics committee throughout the study (Corbin & Strauss, 2015). This study was approved by the Dublin City University Ethics Committee prior to recruitment and data collection. Any further amendments to the design during the process, e.g. permission to use social media campaigns for recruitment, was sent for further review as the study progressed. An application was also submitted to the National Health Research Authority to request permission to collect couple participant data in Northern Ireland. Because the researcher lived in a different jurisdiction, however, it was not possible for them to grant ethical approval for this study. This section discusses ethical issues with regard to participant, researcher and data storage considerations.

Participant Considerations

Social research relies upon building trust and relationships with participants and it is paramount that participants are treated in an ethical manner and in a way that gives due regard both to their rights and to their feelings (Denscombe, 2002). There are four fields traditionally discussed with regard to ethical guidelines regarding participation in research: the role of the researcher, informed consent, confidentiality and consequences (Willig & Stainton-Rogers, 2008) and these concerns also inform the Psychological Society of Ireland's (PSI) Code of Ethics (PSI, 2011).

The Role of the Researcher

The researcher is responsible for the quality of the research and soundness of ethical decisions and can increase confidence in these decisions by outlining them as transparently as possible (Willig & Stainton-Rogers, 2008). With regard to integrity, The PSI's Code of Ethics

state that psychologists “are obliged to be honest and accurate about their […] research findings (PSI, 2011, p. 4). In order to minimize biases during the research process, Corbin and Strauss (2015) recommend that researchers keep an account their reciprocal interactions with participants during the data collection stage and memos during the data analysis stage about the meanings assigned to the data.

According to Mortari (2015) reflectivity involves not only the consideration of the technical and practical aspects of research, but also the experience that constructs meaning during the research. During the data collection stage, field notes were written immediately after the interview to record the dynamic between the researcher and the participants and any thoughts or emotional responses arising from the interviews. Along with each anonymized transcription, these field notes were reviewed by supervisors, and subsequent supervision sessions were used to discuss any issues that arose from these interviews. These field notes were also used as a catalyst to identify any hidden biases or emotional triggers that might have resulted from the interviews, and supervision or external counselling support was used to debrief the researcher about these issues. Personal bias can make the researcher feel uncomfortable listening to, or reporting on, a phenomenon (Corbin & Strauss, 2015). Techniques for reducing bias include audiotaping and transcribing interviews (Laslett & Rapoport, 1975) and keeping a journal in which personal reactions can be recorded during data collection (Corbin & Strauss, 2015). Tuval-Mashiach (2017) recommended that only events and decisions that change the direction of the research are included in a reflective journal. As recommended by Corbin and Strauss (2015), the researcher continuously reflected on her work through writing descriptive and analytic memos, and sharing and discussing how her biases might impact on the research process with her supervisors.

Grounded theory, according to Corbin and Strauss (2015), has built-in checks and balances designed to control biases and assumptions, including writing accounts the meanings assigned to data, and the use of analytic strategies, constant comparisons, and the use of

analytic strategies when coding. While acknowledging that bias can never be completely eliminated in utilising these strategies, the researcher made every effort to remain grounded in the data throughout the analysis process. During data analysis, records were kept of the researcher's responses to the data and the meaning(s) assigned to the data and these were reviewed during supervision. This ensured that the analysis was as free from bias and as true a reflection of the experience of the couples and healthcare professionals as possible. According to Corbin and Strauss, assumptions and biases can have their greatest impact during the analysis stage, for example, when asking questions, interpreting data and making comparisons. Once assumptions and biases have been identified, however, they can also be harnessed in the service of the research, for example, to use the perspectives inherent within one's own field of study (psychology in the case of this researcher) to look for associations rather than descriptions (Darawsheh, 2014). As the research progresses, it is important to share preliminary analysis and findings in order to gain alternative perspectives and to identify any potential biases inherent in the analysis (Valandra, 2012). At regular intervals in supervision and panel meetings, the researcher submitted preliminary findings and pieces of analysis for review and discussion.

The role of the researcher also involves the balancing of professional distance and personal relationships (Willig & Stainton-Rogers, 2008). This especially needed to be considered in the context of the couple interviews. The consideration of power inherent in the research context and the potential to do harm has been emphasised by feminist researchers (Sampson et al., 2008) and is included in many codes of ethics, including those of the PSI. This states that psychologists "shall recognise that psychological knowledge and their own expertise and capacity for work are limited, and take care not to exceed these limits" (PSI, 2011, p. 3). Therefore, it was important to have protocols around providing support for participants if required, as the researcher is an academic psychologist, not a professional psychologist practitioner. In the case that participants experienced emotional upset during the

interview, the researcher was able to intervene to offer immediate support, to postpone or cancel the interview as required, and to offer further support, if needed, by providing information regarding appropriate counselling services (Dempsey et al., 2016; Kuyper et al., 2014). All of the participants who took part in the interviews completed the full schedule of interview questions. Some couple participants had resolved the vaginismus and had access to support and did not require any additional help. For couples who were experiencing vaginismus and who were currently not linked in with any support services, information was provided. In addition, the Healthy Living Centre in Dublin City University agreed to provide a free counselling session with a psychosexual therapist and referrals for couples who required it. Couples who had not resolved the vaginismus at the time of interview and were not currently linked in with services were given the contact details for the Healthy Living Centre and all of the couple participants who had not resolved the vaginismus chose to avail of this opportunity.

Informed Consent. Informed consent involves providing potential participants with all of the information that they would require in order to make a decision as to whether they want to take part in the research. This includes the aim of the research and a clear picture of not only what will occur but what might occur including any potential risks (Lee, 1993). With regard to the respect for the rights and dignity of the person, the PSI's Code of Ethics states that psychologists should "ensure that clients understand and consent to whatever professional action they propose" (PSI, 2011, p. 3). It is important that participants participate in the research voluntarily and are not coerced in any way (Walton, 2016). As recommended by Corbin and Strauss (2015), participants who agree to take part in the study were provided an opportunity to discuss and sign the consent form to ensure that they fully understood what was involved in taking part in the study and to emphasize that their participation was voluntary and that they could withdraw at any time. Current interpretations of informed consent involve more than a one-off activity of securing consent at the beginning of the

research. Informed consent also includes demonstration of appropriate and systematic assessment of risk, privacy and protection, safety and potential harm, trust and responsibly (T. Miller et al., 2007). Communication technologies afford the researcher an opportunity to systematically document the securing of informed consent (T. Miller et al., 2007). Information sheets giving detailed information about the study were sent to potential participants via email in advance for their consideration. Consent forms were discussed and signed by all participants prior to the interview and the researcher engaged in ongoing risk assessment in the dynamic context of the interview.

Confidentiality. Confidentiality means that identifying information will not be reported without the consent of the participant and concerns include issues of privacy and anonymity (Willig & Stainton-Rogers, 2008). Tolich (2004) distinguishes between external and internal confidentiality. External confidentiality is a commitment not to identity the person directly, internal confidentiality is a commitment not to identify the person indirectly by providing information that would allow deductive disclosure. To ensure external confidentiality when dealing with sensitive information, it is recommended that pseudonyms be used and research sites disguised (Corbin & Strauss, 2015; Lee, 1993) and that demographic characteristics of the participants and any third parties mentioned may need to be altered (Hadjistavropoulos & Smythe, 2001). To ensure internal confidentiality, when using quotations and examples of people that have faced unusual life events, care must be taken that details do not lead to identification via deduction (Kaiser, 2009). Professional participants were asked not to speak about any individual clients or to identify them in any way during the course of the interview. All participants were informed that some direct quotations from the interviews would be used for illustrative purposes but were assured that no identifying information would remain linked to the data; only pseudonyms would be used in publications and in the thesis. As recommended by Charmaz (2015), to ensure absolute confidentiality, the interviews were transcribed and anonymised by the researcher herself and only the anonymised versions were

available to supervisors for review. The interviewees were informed that no one but the researcher and her supervisors would have access to the anonymised interview transcripts.

It is also important to make participants aware of limits to anonymity and confidentiality. Although guarantees of confidentiality can be made, it is important to note that there are legal limits within interview contexts, e.g. the disclosure of information suggesting that vulnerable people are at risk (Lee, 1993; Walton, 2016). Participants were advised prior to the commencement of the interview that, in specific instances such as disclosures of child abuse, mandatory reporting procedures would be followed in line with Children First legislation (DCYA, 2017). With regard to the related issue of anonymity, absolute anonymity is precluded by face-to-face interviews. Anonymity means that the source of participant data is unknown even to the researcher (Wiles et al., 2006). In the case of some professional participants, it may have been possible to identify the participant, e.g. if they were the only person who occupied a particular professional post. In cases such as these, it is important to highlight this and to give the participant the chance to proceed or withdraw (Walton, 2016). This was explained to participants; none of the professional participants chose to withdraw.

In order to ensure confidentiality, all participants had the opportunity to read over the anonymised transcribed material (Kent, 2000). Corbin and Strauss (2015) state that if participants request the removal of information from a transcript, the researcher is obliged to do so (Corbin & Strauss, 2015). All participants had the opportunity to delete, to add or to modify information in the first draft of the transcript. Any changes in terms of deletions, insertions or additions requested by participants were made to their transcript prior to analysis. Only the amended versions of the twenty-eight transcripts were reviewed by supervisors and included by the researcher for the purposes of analysis.

According to Knox and Burkard (2009), meeting a second time is generally welcomed by participants and serves to increase participants' sense of safety, to clarify points made during the first interview and to add more information in the context of looking back at the first interview. Meeting a second time allows for initial anxieties and resentments felt by the interviewees in the first interview to settle leading to a deeper analysis in the second interview (Laslett & Rapoport, 1975). It is entirely possible that the interviewee may have regrets after the interview if they feel they have been unfair, inaccurate or indiscrete and it can be helpful to have the opportunity to read over their transcript to remind them of what they have said and to allow them to make necessary amendments (Gillham, 2005). Repeat interviews can also be used as an opportunity to give something back to the participants (Laslett & Rapoport, 1975).

None of the professional participants requested a second meeting. Transcripts were sent by registered post to the six professional participants that requested reviewing their transcripts. The transcripts were either returned to the researcher via post with amendments written on the transcript, or they were amended by the researcher through during a telephone discussion. If couple participants requested reviewing their transcripts, they were given the opportunity to do so only in the presence of the researcher. Only three out of the ten couple participants requested reviewing their transcripts. For those who requested it, a second meeting was arranged and all changes requested were recorded and verified in the presence of the couple. If a lot of changes were requested, these conversations were audio recorded and transcribed to ensure accuracy when making changes later. One couple requested no changes, two couples asked for minor changes that served to clarify what they meant to say when they felt that certain points had not been explained clearly enough. These changes were not thought to be significant enough to have any impact on the analysis of the data. Having the opportunity to review their transcripts allowed participants to have a feeling of control over the information that was disclosed in the interview and also a chance to debrief after the initial

interview. The repeat interview not only gave participants the opportunity to process the interview further and make comments that they felt were important but also gave a second opportunity to ask couple participants about their experience of the interview and to direct those in need of help towards appropriate support services. All participants were asked if there were issues that perhaps should have been asked about in the interview and advice they would give to couples who were having similar experiences and thus participants were also given the opportunity to shape the future direction of the project.

Consequences. It is important to consider the consequences to the participants in order to justify requests for their participation in the research. With regard to responsibility for the consequences to the participants, the code of ethics of The PSI's Code of Ethics state that psychologists have the responsibility to "act in a trustworthy, reputable and accountable manner […] They shall avoid doing harm to […] research participants" (PSI, 2011, p. 4). When considering the consequences of research, it is important to look not only at the potential risks to participants but also potential benefits of participation.

Discussing sensitive topics can be emotionally difficult for people, however some authors have challenged the notion that participants be precluded from doing so simply because interviews are emotionally difficult, viewing the exclusion of individuals considered vulnerable as misguided protecting. There has been a rise in therapeutic orthodoxies that has permeated many areas of society, for example, that difficult early life experiences have long-term emotional effects that creates a "diminished self," which is fragile, vulnerable and in need of support (Ecclestone & Hayes, 2009, p. xi). A panel convened by the National Institute of Mental Health concluded that considering certain people too vulnerable to participate in research and putting measures in place to protect them may cause new forms of harm including restricting an individual's right to exercise autonomy, unfairness, the reinforcement of stigma and the unnecessary restriction of research (DuBois et al., 2012).

They concluded that a balance should be struck between protecting people from adverse influence and respecting their ability to make an informed decision.

A Dutch study that analysed the cost-benefit ratio of participating in sex research found low levels of distress and high levels of positive feelings (Kuyper et al., 2014). According to Corbin and Morse (2003) research participants, even if they are unaware of it, expect something in return for their participation. The authors suggest that one motivation might be the need to vent their feelings. Participating in research has been shown to be therapeutic and have an emotional benefit for most people who participate. It allows participants to be heard, to be involved in conversation about taboo issues affording an opportunity to make sense of these experiences and to contribute to the well-being of other people in similar circumstances by sharing these experiences (Lakeman et al., 2013). The majority of people who participate in research that involves discussing traumatic experiences indicate that the benefits of taking part in research outweigh the potential costs including the experience of distress and most participants do not regret participating (Jaffe et al., 2015; Newman & Kaloupek, 2009). Persons who are more emotionally fragile usually do not volunteer to take part in interviews because the distress aroused would be greater than any benefit arising from the opportunity to talk (Corbin & Morse, 2003). In addition, those who do volunteer to speak about emotionally sensitive topics have been found to have reflected upon their motivation for participation prior to volunteering and their decision on whether or not to participate in research should be respected (Dyregrov et al., 2011).

The ethical principle of beneficence means that the risk of harm to a participant should be minimal and the importance of the knowledge gained should outweigh the risk of harm to the participant and the larger group they represent (Kvale & Brinkmann, 2009). When considering the risk-benefit ratio to participants, sometimes the benefits for partaking in research can be overlooked. Participants have the right to be heard and if they volunteer for a research study and sign a consent form, they are indicating that they want to tell their story

(Corbin & Strauss, 2015). Being permitted to speak about sensitive issues can prove to be a beneficial and therapeutic experience for participants (Lee, 1993). Couples with vaginismus and health care providers who work with couples with vaginismus potentially benefit from the study in a number of ways. The study not only gives an opportunity to talk about their experiences of vaginismus but also to contribute to the development of a theory of vaginismus within an Irish context that will provide a new understanding of vaginismus that may have a beneficial impact for individuals, couples and health care providers and more sensitive responses by health care professionals.

Researcher Considerations

Researcher Risk. As well as the risk to participants, it is also important to consider any potential risks to the researcher. In applying for ethical approval often the focus is on risk to participants and risks to researchers themselves is often an under-examined consideration (Dickson-Swift et al., 2005). The term "risky research" has been recently applied to any research that entails risks to the researcher including sensitive subject matter such as sex research (Webber & Brunger, 2018). Investigating topics of a sexual nature carries both professional and personal risks to the researcher. The risks to researchers can be physical, psychological and emotional but in ethics applications usually only the risk of physical harm is highlighted (Dickson-Swift et al., 2005). Conducting research into sexual topics can be emotionally distressing and can entail both professional and personal risk. For example, the researcher may be marginalized and stigmatized by colleagues and can negatively affect opportunities for promotion and the reputation of the person undertaking the research who may be assumed to be sexually deviant, undermining traditional values or being personally affected by the topic under investigation (Troiden, 1987). This may influence the researcher to avoid controversial topics (Dickson-Swift et al., 2005). The effect on the researcher of hearing participants' stories also needs to be considered (Lee, 1993). There is a danger that

researchers will experience vicarious trauma (Newell & MacNeil, 2010) or suffer from emotional burn out due to the emotional toll of hearing about distressing experiences (Dickson-Swift et al., 2005).

However, there are personal benefits to the researcher that offset these potential risks. These benefits include knowing that the research is making a real difference to people’s lives by reducing sexual ignorance and sexual guilt. It can be an opportunity for both personal and professional growth as quite often the researcher has to develop a strength of character that enables them to overcome their own inhibitions and in so doing become more proficient researchers and teachers (Troiden, 1987). Rather, Webber and Brunger (2018) suggest that rather than ethics committees bearing the burden of setting boundaries with regard to research around sexual topics, they should instead assess what constitutes acceptable risk for the researcher. When conducting research, it is ultimately up to the researcher to take their own personal safety into consideration (Walton, 2016) and to put protective measures in place (Sampson et al., 2008).

In this instance, there were no risks to the researcher associated with interviewing professional participants. With regard to interviewing couple participants, there was deemed to be a minimal risk to the researcher as couples may choose to be interviewed in their homes, which can place the researcher in a vulnerable position. This risk was reduced by arrangements between the researcher and supervisors that the researcher notified the supervisors by text message when travelling to the participants' home and again on leaving the participants' home. The potential impact of hearing traumatic or emotionally difficult stories was anticipated and deemed to be an acceptable risk because the researcher had prior experience of interviewing patients who were sharing upsetting stories in hospital settings, e.g. oncology. The researcher had access to ongoing support from supervisors and external counselling supports during the project, when necessary.

Researcher Reflexivity. Reflexivity in qualitative research is viewed by some as the explicit quest to limit researcher effects on the data by awareness of self (McGhee et al., 2008). Others view it as the researcher's awareness of how their own experiences, biases and values influence the collection and analysis of data (Creswell & Poth, 2018). Given that reflexivity is not a natural tendency of the mind, the researcher needs to be trained in this regard (Mortari, 2015). As outlined above, the Straussian grounded theory method employed in this study contains specific strategies for enhancing reflexivity such as writing field notes and analytic memos. Coming from a background of quantitative research, I found these strategies helpful for identifying and limiting bias throughout the research. This process was supported by discussion and reviewing of these reflective notes in research supervision.

Straussian grounded theory is rooted in a pragmatist approach (Strauss & Corbin, 1998), and the pragmatist perspective on reflexivity centres on its ability to increase effectiveness by learning from experience (Mortari, 2015). It is possible to not only to engage in reflection-on-action (Schon, 1987) but also to engage in reflection-before-action (Greenwood, 1992) to foresee and prepare for the avoidance of problems. One important aspect of this reflection, considering the emotive content of the interviews, was the emotional impact on the researcher. It was necessary not only to acknowledge this in supervision but also to have access to external counselling supports when necessary. In starting the interview process by interviewing professional participants, my awareness of the experiences of women and couples experiencing vaginismus increased and prepared me for what might come up in the couple interviews. This also afforded me time to acknowledge any preconceptions that existed about vaginismus prior to interviewing couples. For example, at the beginning of the research project, I had limited knowledge of any benefit of the pelvic examination for women. However, some of the professionals spoke of its benefits including how the examination may alleviate fears that the genitalia are abnormal and how it can act as a way of opening up the conversation with clients. Although most of the women in the couple interviews had not

experienced internal examinations as therapeutic, the woman in first couple interview spoke positively about her experience with a doctor who was sensitive and knowledgeable about vaginismus. These experiences increased my awareness of this bias and helped me to engage in reflection-before-action, in the hope of minimising this bias from the interview process.

The couple interviews were often emotionally upsetting for the couple participants. During the interview, some couples became very distressed and cried. Some couples were grieving because they perceived that vaginismus had taken so much from their quality of life including, for some, their ability to be intimate with one another, and for others, their felt loneliness and isolation or their ability to have children. Some couples were angry because of the response they had received from medical professionals, or the lack of awareness about vaginismus. Some couples were openly hostile to one another during the interview. I felt competent in the moment in being able to maintain a healthy emotional distance by focusing on the task of interviewing, while at the same time offering immediate support if necessary by offering to postpone or cancel the interview and providing information about counselling services. After the interview, however, and particularly during the transcription, I often found myself feeling very emotional when listening back to the interviews and empathising with the anger, sorrow, distress and grief that were audible in the interviews. These experiences were noted in field notes, discussed in supervision and, when necessary, in counselling sessions. I believe my awareness of my emotional response evoked by the participants ensured that my analysis of the data captured the richness of experiences that the participants were attempting to convey during these interviews.

Data Storage Considerations

It is the responsibility of the researcher to makes sure that information is stored securely and used only for the purposes for which it was collected (Denscombe, 2002). Data management strategies were put in place prior to the collection of data in accordance with

Dublin City University Data Handling Guidelines (DCU, 2018). All interviews were stored on a recording device on the researcher's iPhone, which was protected by a PIN number. Following immediate transcription of interview by the researcher herself, the audio record of the interview was completely deleted (Corbin & Strauss, 2015; Lee, 1993). When transcribing, any identifying information was deleted from the transcript so no one apart from the researcher had any identifying information regarding participants. With regard to data storage, all hard copies of data should be stored in a locked filing cabinet and all soft copies should be stored on a password protected computer (Gillham, 2005). Because of the sensitive nature of the data, further precautions were taken. First, all identifying information was stored on a password protected, encrypted excel file that was password protected and stored on the desktop computer in the researcher's office. Each participant was designated a code number on the excel file and these code numbers were assigned to the interviews.

The printed transcripts were kept in a locked filing cabinet to which only the researcher had access. As a further precaution, the consent forms, which are potentially identifying as they are required to contain the signatures of the participants, were stored in a second locked filing cabinet separate from the transcripts. Back-ups of the data were also stored separately from the printed transcripts. The transcripts were also stored electronically on the researcher's password protected encrypted desktop computer and also in a secure password protected cloud storage system managed by Dublin City University. Supervisors accessed the anonymised transcripts through the Dublin City University-managed Google Drive secure cloud based storage system only. Therefore, there were no links between any identifying information and the transcripts which, in any case, were fully anonymised. It is important to make a plan for the destruction of data that has served its purpose (Gillham, 2005). In the case of this project, the approved institutional guidelines for destruction of data outlined in the Dublin City University Data Handling Guidelines will be applied. The most recent PSI guidelines on confidentiality and record keeping practices require researchers to

retain research data for a period of seven years. When this time period expires, all paper copies of the data will be shredded and storage media will be disposed of by Information Systems Services in Dublin City University.

Method

Methods are defined by Strauss and Corbin as, “a set of procedures and techniques for gathering and analysing data” (Strauss & Corbin, 1998, p. 3). In qualitative research, a preliminary research question is often formulated without reference to particular individuals, organisations or data collection sites. The task of the researcher is to design the study by firstly developing sampling and recruitment criteria and secondly data collection procedures that are capable of answering that research question (Devers & Frankel, 2000). The following section outlines the design of procedures for sampling, recruitment, data collection and analysis undertaken in this study.

Sampling and Recruitment Criteria

In order to answer the research questions for this particular study, it was necessary to interview two distinct groups of participants: couples who had experience of vaginismus and seeking help in Ireland and professionals who had experience of working with couples and individuals who have experienced vaginismus. At the beginning of a research project it is important to outline a strategy for sampling potential participants (Devers & Frankel, 2000). Strauss and Corbin advocate theoretical sampling, which they define as “sampling on the basis of emerging concepts, with the aim being to explore the dimensional range or varied conditions along which the properties of concepts vary” (Strauss & Corbin, 1998, p. 73). Because data collection and analysis occurs simultaneously, the analysis develops concepts that drive future sampling. Sampling should continue until theoretical saturation of each category has been accomplished (Glaser & Strauss, 1967; Strauss & Corbin, 1998). Corbin

and Strauss (2015) recognise, however, that not all researchers have the ability to theoretically sample because of restrictions on where, when and from whom to collect data. This project was an exploratory study of a phenomenon that has not been investigated in Ireland in almost forty years and so it was unclear who the most appropriate participants to interview might be. It was deemed more prudent, therefore, to use as many avenues of recruitment as possible and to interview everyone that applied. To this end, the study used a mixture of purposive, snowball and convenience sampling.

With regard to the recruiting of professional participants, purposive sampling was used in the first instance and then snowball sampling. Purposive sampling involves choosing a small sample based on both their relevance to the phenomenon under investigation and their knowledge and experience of the topic (Denscombe, 2002; Elo et al., 2014). Professional participants were contacted based on their membership of certain regulatory organisations who are qualified in psychosexual and/or couple therapy, e.g. COSRT, IPM, IACP or in their professional capacity as a member of staff in public or private clinical settings that treat individuals and couples for psychosexual problems. Data collection began with professional participants who, at the end of the interview, were asked to suggest colleagues or clients who might want to be interviewed and were given information to pass on if they were comfortable to do so, a sampling technique known as snowball sampling. Snowball sampling is thought to be particularly useful for researching sensitive issues that might require insider knowledge to suggest relevant people for the study (Biernacki & Waldorf, 1981).

Interviews with professionals can be considered to be elite interviewing, which "involves talking to people who are especially knowledgeable about a particular area of research or about the context within which you are researching […] commonly in positions of authority and power by virtue of their experience or understanding" (Gillham, 2005, p. 54). Professionals are frequently part of information networks and they may act as gatekeepers, controlling or facilitating access to relevant participants (Gillham, 2005; McAreavey & Das,

2013). It is important for researchers to provide adequate information about the research in order to build trust (McAreavey & Das, 2013). Where agencies had concerns about their clients being involved in the research, as can be the case with sensitive subject matter (Gillham, 2005), the researcher offered to conduct presentations at team meetings within those agencies in order to build trust and develop rapport with staff. There is also a risk that the professional participants could use their senior positions to steer the research in a particular way by disclosing and not disclosing certain information and suggesting other likeminded participants for further interviews. This can be offset by using a sampling technique in grounded theory called negative case sampling where efforts are made to interview a participant as different from the last participant interviewed as possible (Krefting, 1991). Whether negative cases are actually found or not, it is advisable to search for these negative cases in order to offer alternative explanations to the ones that are represented in the research (Corbin & Strauss, 2015). The researcher made efforts to interview a wide variety of professionals who work with couples including psychosexual therapists with a range of training and theoretical orientations, family doctors, consultants and physiotherapists in order to have a fuller explanation of the phenomenon under investigation.

With regard to couple recruitment, convenience sampling was used. Convenience samples are deemed suitable for exploratory studies (Sudman & Kalton, 1986) and provide the researcher with a method of sampling to gather the most relevant data by selecting from those who are readily available to be interviewed (Strauss & Corbin, 1998). In order to take part in the study, it was necessary that all couples voluntarily contacted the researcher to begin the process so it was necessary to use as many avenues as possible to reach potential participants. A dedicated website (http://www.vaginismusresearchireland.com), twitter feed (@irishvaginsimus) and Facebook account (Vaginismus Research Ireland) were set up to provide information about the study and help-seeking in Ireland. Various print newspaper, magazine and online articles were written to highlight the research project (McEvoy et al.,

2018a, 2018b; Moynihan, 2019; OKeefe, 2018a, 2018b), and following their publication the researcher discussed the study on radio (Moncrieff, 2019). Recruitment posters were also distributed to agencies that provided help and support for individuals and couples with vaginismus to display in waiting areas. A copy of the recruitment poster is located in Appendix A**.** All couples that applied to be interviewed for the study and met the criteria were included in the research. In order to be eligible for the study, the couples had to be over eighteen, in a relationship for at least three years, and the woman affected by vaginismus must have grown up in Ireland. Information sheets giving detailed information about the study were sent to all potential participants via email in advance for their consideration and, if they chose to take part in the study, interviews were arranged via private email correspondence.

Grounded theory methodology recommends that rather than deciding on the number of interviews to conduct at the outset, data collection should continue until there is saturation of relevant categories. The point of saturation is reached not only when new categories and themes are no longer emerging but also when the categories have been explored in depth, show variation and are integrated (Strauss & Corbin, 1998). At the start of a research project, therefore, it is not possible to estimate how many interviews will be needed but it is often required by ethics committees and to prevent the need to return to the review board to ask for additional participants, it is often advisable to request a larger amount of participants than may be needed (Strauss & Corbin, 1998). Bearing in mind that saturation is affected by the research question, the sensitivity of the phenomenon and the skill of the researcher, a content analysis of one hundred grounded theory studies concluded that the average sample size was twenty-five and that thirty was recommended in order to fully develop the categories of the given phenomena (Thomson, 2011).

Couple Participants. In total, forty-four women who had or were currently experiencing vaginismus applied to take part in the study. The women were eligible for the study if they had been given a diagnosis of vaginismus or self-reported as having vaginismus.

Therefore, a diagnosis of vaginismus cannot be definitively confirmed in all cases and the sample may, therefore, have included women with similar diagnoses such as vulvodynia, which is defined as “a chronic pain disorder characterised by constant or recurring complaints of vulvar pain or discomfort” (Masheb et al., 2002, p. 253). Twenty-seven were ineligible to take part because they were either not currently in a relationship (n=11), their partner would not consent to be involved (n=11), the problem had resolved in a previous relationship before they met their current partner (n=3), they were non-national and did not grow up in Ireland (n=2). In addition, seven initially agreed but due to various reasons were not able to ultimately participate.

Ten couples took part in interviews. The ages of the couples ranged from 20s to 50s; five of the couples were in their thirties, two couples were in their twenties, one couple was in their forties and two couples in their fifties. Three of the couples heard about the study on the Newstalk interview, four had read one of the media articles about the study, one contacted the researcher via the website, one contacted the researcher via the Facebook account and one heard about the study by a professional participant. To meet the study criteria, all of the women were Irish nationals had been with their partner/husband for more than three years. No additional demographic information was recorded due to concerns that it could potentially identify couple participants.

Seven of the couples in the study were currently experiencing primary vaginismus in their relationship; two had resolved the problem at the time of the interview, five and had not. Three of the couples had experienced secondary vaginismus and two had resolved it.

Professional Participants. Eighteen professional participants consented to be interviewed; fourteen psychosexual therapists, one obstetrician and gynaecological consultant, one physiotherapist and two family doctors. All of the professional participants were female except two of the psychosexual therapists. Fifteen of the professionals worked in the Republic of Ireland and two therapists and one medical doctor worked in Northern Ireland.

Data Collection Design and Procedures

Semi-Structured Interviewing. Interviews are the most common data collection method that is used in grounded theory studies (Charmaz, 2003). And are also considered to be highly compatible with grounded theory methods (Willig, 2001). Strauss and Corbin view theory as something that the researcher and participants create together (Strauss & Corbin, 1998). Knowledge is constructed in the interaction between researcher and participant in a research interview (Kvale & Brinkmann, 2009). Interviews based on a semi-structured design enable the interviewer to have a clear list of topics that are flexible in terms of the order in which they are answered and allow the respondent to elaborate on key points (Denscombe, 2002). Semi-structured interviews ask the same open-ended questions but the questions can be developed as interviews progress and probes can be used flexibly as supplementary questions (Gillham, 2005). One of the key advantages of semi-structured interviews for exploratory studies such as the one presented here is that its structure facilitates analysis of commonalities while the open-ended nature of the questions facilitates the uncovering of new, unique or variable information.

Semi-structured interviews were therefore considered to be the most suitable method of data collection for this research study. With regard to participants, interviews are suitable for collecting data from participants with an in-depth knowledge of particular phenomena (Denscombe, 2002). The open-ended nature of the questions allowed the interview schedule to be used flexibly in order to interview professionals with diverse approaches to the understanding of vaginismus and how best to work with individuals and couples. With regard to couple participants, interviews are highly suitable to the exploration of complex phenomena such as sensitive issues because participants are given the opportunity to discuss personal information and explore feelings and experiences in an open manner (Denscombe,

2002). In addition, in the case of this study, interviewing couple participants together made it possible to observe interactions between the couples during the interview process.

Interview Design and Procedures. In its original conception, grounded theory recommended that no literature search took place prior to data collection (Glaser & Strauss, 1967), the Straussian and social-constructivist versions of grounded theory later recommended being familiar with the literature in order to design interview topics that will be of relevance to participants (Charmaz, 2006; Corbin & Strauss, 2015). A comprehensive literature review allows researchers to identify what areas are known and potential avenues of inquiry (Gillham, 2005) and for the project to be guided by informed expectations (Miles & Gilbert, 2005). It is recommended that a thorough literature review be done in advance of designing interview schedules as it helps to focus questions in order to create meaningful data (Jacob & Furgerson, 2012) and ensures that the researcher is well informed about the issues that might arise during the interview (Denscombe, 2002). A full review of the literature provided areas of interest for the interviews (Elliott & Timulak, 2005) and these were grouped into topic categories, which were set out in a logical narrative order (Gillham, 2005).

Open ended questions are recommended for studies that want to afford the participants the opportunity to provide additional information (Jacob & Furgerson, 2012). As well as being open-ended, the questions in the interview schedule contained devices for eliciting more information known as probes and prompts. Probes can range from asking questions or using responsive encouragement (Gillham, 2005). Some probes that were used as part of the interview included: asking for clarification or specific examples, extending the narrative in order to find out what happened next, or using reflecting techniques to feedback what was said in order to give focus and to encourage elaboration (Gillham, 2005). Prompts are devices that allow the researcher to refer to questions simultaneously allowing for unintended information to be offered (Jacob & Furgerson, 2012). The most frequently used prompt in this interview schedule involved using the phrase "Tell me more about…" as a device for eliciting

more information about a particular topic of interest. Using the phrase "tell me about" is a useful device for starting a question because it invites the telling of a story in whatever way they wish and the use of big expansive questions such as these allows the participant to speak uninterrupted (Jacob & Furgerson, 2012).

Sometimes when unexpected data did emerge, it was necessary to ask unexpected questions but this is in line with the emergent nature of qualitative interviewing (Jacob & Furgerson, 2012). Open-ended questioning also refers to a flexible attitude towards data gathering that allows for each interview to be adapted to be specific to the participants' unique experiences (Elliott & Timulak, 2005) and offers another way to bracket the researcher's preconceived ideas (Kvale & Brinkmann, 2009). For example, based on interviews with professional interviews, the very general question asked to couples at the start of the trial interview: "Tell me about your experience of vaginismus?" was broadened to include topic areas that emerged from previous interviews and was broken down and asked in the following way in order to elicit more information:

Interview Schedule for Couples (EXERPT)

1. When did you first notice that there was a sexual difficulty?

Prompts: What did you notice?

How did it develop over time? If so, what have you noticed?

2. When the difficulty became apparent, how did you cope with it?

Prompts: How did you respond?

How did your partner respond?

3. Tell me about the impact vaginismus has had on your relationship?

Prompts: Did vaginismus make you feel differently about yourself?

Did vaginismus make you feel differently about your relationship?

Interviews were audio-taped so that a complete record of the interview was available for analysis and for supervisor review (Denscombe, 2002). The disadvantage of audio-recording is that other contextual factors such as non-verbal cues can be missed (Denscombe, 2002). However, each stage of the research was also supported by written records of analysis known as memos. Descriptive and theoretical memos were written following each of the interviews. Detailed examples of the use of memos for theoretical development during the data collection process are included in the following sections.

Trialling the Interview Questions. Trialling refers to a first draft of the questions, which should be shown to someone experienced in the area for review (Gillham, 2005). Trial interviews were conducted with one therapist and one couple in advance of data collection. In line with grounded theory best practice, these questions were adjusted to include concepts derived from the data that emerged from these interviews (Corbin & Strauss, 2015). Feedback from these sessions were used to add new questions, remove questions that did not add to the interview and to make slight changes to the ordering of the interview questions. For example, feedback from the trial interview with a couple suggested that the opening question: "Tell me about your experience of vaginismus" was too broad and not suitable as an introductory question. This question was replaced with a question suggested by the participants themselves which was: "Tell me about when you first noticed there was a difficulty?" It is important to practice interviewing prior to embarking on data collection (Gillham, 2005), and these trials not only facilitated the honing of interview skills but also transcribing and memo writing skills prior to the first phase of data collection. The data collected in the trial interviews were not used for analysis as they were never intended to be included. In line with best practice, they were used to assess the validity of the interview schedule in progress and to highlight any practical problems faced by researchers, e.g. leading questions (Jacob & Furgerson, 2012; van Teijlingen, 2001). For example, questions that began with "Can you tell me about…"

were replaced with questions that began with "Tell me about…." as the first question can be perceived as a binary response (yes or no) rather than an open-ended one.

Although the trial interviews and a literature review were instrumental in forming the first draft of the interview schedules, grounded theory methods allow for data collection procedures to be continuously influenced by analysis (Glaser & Strauss, 1967) and so the interview questions were revised throughout the data collection period. Corbin and Strauss (2015) recommend that the literature continues to be renewed during the analysis to elaborate on concepts and themes as they emerge and to use as data. They further suggest that familiarity with the literature can also enhance sensitivity to the data as long as the distinction between concepts derived from the data and those imposed on the data are made clear.

Data collection. Gillham (2005) suggests that the interview process can be divided into five distinct phases: the preparation phase, the initial contact phase, the orientation phase, the substantive phase and the closure phase. In the preparation phase participants are made aware of the particulars of the research and their role. All participants who volunteered for the study were sent the information sheet with all of the information about the research, topic areas for interview questions and contact information for the researcher in advance. The interviews took place at a mutually agreed suitable time and location and the participants were given the question topics in advance of the interview. The interviewees could choose to be interviewed at their own homes or a neutral environment to preserve privacy (Laslett & Rapoport, 1975) such as Dublin City University. During the initial contact phase, social exchanges were made to make the participant feel at ease. In the case of professional participants, social exchanges of this nature were not always necessary or practical as the interviews often took place at their place of work between appointments. In the case of couple participants, this was always necessary.

During the orientation phase, it is necessary to provide an explanation of the research and the purpose of the interview. Copies of the information sheet were provided in case participants had not had a chance to review them prior to the interview. A copy of the information sheets for the professional and couple interviews are located in Appendix B and C respectively. Participants were asked if they had any questions prior to signing the consent form, which also outlined the limits of confidentiality. A copy of the consent forms for the professional and couple interviews are located in Appendix D and E respectively.

The substantive phase of the interview involved asking the topic questions and using prompts and probes to facilitate elaboration of information. A copy of the interview schedule for the professional and couple interviews are located in Appendix F and G respectively. The closure phase affords an opportunity to participants to add anything that may have been missed or comments about the research project and asking whether they would like to review the transcript (Gillham, 2005).

A request can be made to participants to allow the researcher to return to the participants with the transcripts and to ask additional questions that may have emerged since the first interview (Jacob & Furgerson, 2012). If participants agreed to a second meeting it became a valuable opportunity to check the accuracy of the transcript with them, to ask additional questions and to allow them to provide additional information. Asking follow-up questions affords the interviewer the opportunity to change questions based on participants' previous responses (Turner, 2010). A copy of the interview schedule of follow-up questions for couple participants who chose to meet a second time is located in Appendix H.

Transcribing and Memoing. Transcribing is the process of producing a valid written record of an interview (Gillham, 2005, p. 121). The focus for grounded theorists is on the meanings contained in a transcript as opposed to the empirical analysis of speech (Oliver et al., 2005). During transcription, an opportunity is given for interpretation as the act of

transcribing stimulates the development of themes or categories (Gillham, 2005). Transcribing enables the researcher to have greater familiarity with the data to be analysed (Charmaz, 2015).

In order to build a theory it is imperative that grounded theory researchers write memos throughout the research process to create concepts from raw data, to make statements of relationships between the concept and integrate them into a theory (Corbin & Strauss, 2015). Memos are written records of analysis (Corbin & Strauss, 2015), were used at every stage of the research, to make descriptive notes immediately following the interview, to add further description when transcribing and writing conceptual memos during analysis. In the open coding stage, memos consist of initial impressions, thoughts and directions. Memos can be discursive or contain graphical representations (Alvesson & Skoldberg, 2000). Early notes highlight common words, metaphors and themes (Creswell, 1998). They include concepts and the categories to which they might point, including their properties and dimensions (Strauss & Corbin, 1998) and should also include reflective notes (Creswell, 1998). While transcribing, the researcher simultaneously wrote memos so that as much detail from the interview could be retained as possible and parts of the interview could prompt future analysis. Transcribing can therefore be thought of a valuable stage of pre-analysis (Elliott & Timulak, 2005).

In order to enhance theoretical sensitivity in the early stages, Straussian grounded theory recommends asking questions and making comparisons (Corbin & Strauss, 2015; Strauss & Corbin, 1998). Many of the strategies designed to stimulate questions and comparisons recommended by Strauss and Corbin (1998) and Corbin and Strauss (2015) were used by the researcher to develop concepts. One strategy that the researcher used frequently involves thinking about the various meanings of a word using the flip-flop technique or by using metaphors. The flip-flop technique requires the researcher to think about a concept from many different perspectives. Below is an excerpt from a memo dated 17.5.17 that used the

flip-flop technique and reflective analysis in order to think about the various meanings of the word “protection” and references a previous memo on the theme of collusion.

MEMO EXCERPT: Exploring the Various Meanings of a Word – the Use of the Flip Flop Technique 17.05.17: Exploring the meaning of the word Protection.

1. The flip-flop technique involves turning a concept upside down to obtain another perspective. We associate protection with someone more vulnerable being taken care of by a more powerful person, for example a mother caring for a child. But in this case, the concept seems to be flipped on its head where a child is protecting the mother and catapulted into the role of the caretaker. Therefore, the boundaries in the family between child/adult may be somewhat blurry and this blurry boundary may also make it more difficult for the child to grow into adulthood. This was a theme in the previous Memo-Collusion with the metaphor of the “babe in the wood” trying to journey from childhood to adulthood. Perhaps negotiating the way is made more difficult because there has been no female adult to model growing up. Perhaps the mother has never negotiated her way out of the wood either.

2. Protection has the negative connotation of being *“wrapped up in cotton wool”* and the connotation of this metaphor is being shielded from the experiences that are important for growth & development (e.g. learning about the body, learning about sanitary hygiene and contraception, engaging in sexual relationships) and being suffocated in the family.

3. Protection can also be linked to the idea of threat and to the previous P001 Memo-Threat. This memo discussed the culture of ‘protection’ from sexual matters that appears to exist in Irish culture that deals with threat through censoring information and fear messages. The same approach used in the Irish family. Protection or control?

During analysis, memos become more conceptual than descriptive and they contain conceptual headings that can be used to cross-reference memos with similar concepts (Corbin & Strauss, 2015). For example, from a memo dated 30.11.17, there is a comparison of the enmeshed mother-daughter relationship from interviews with professionals and a reflective piece that links back to the original studies on vaginismus conducted in Ireland more than thirty years ago.

MEMO EXCERPT: Conceptual memo discussing the concept of the mother-daughter enmeshed relationship 30.11.17

'I always think nearly everything comes back to the mother…that first relationship…there is a huge component in attachments (Therapist Boann: p.32). The daughter has problems with differentiation and does not seem to develop her own mind sufficiently (Therapist Bebhinn: p.32 & p.11). They have 'layers of guidance from their mothers' and there is a real difficulty in separating out from her and a profound lack of curiosity or development in themselves. They accept the rules and standards they have internalised and takes on that identity without ever considering an alternative because they have grown up in a very sheltered way and have just accepted what authority figures have told them (Therapist Bebhinn: p.11-12). The mother tends to be the dominant personality in the family for the daughters, so although the father might be head of the household, 'she is ultimately the one who has more control over what happens' (Therapist Bebhinn: p.12). With vaginismus the mother role seems to contribute more to hang-ups and resistance arounds sex (Therapist Boann: p.32). Even when she has her own relationship the daughter might continue to be inappropriately involved in her family of origin (Therapist Nemain: p.3) and to keep in contact with the mother to an unreasonable degree or even continue to live with her (Therapist Bebhinn: p.13).

Sometimes the relationship is not a pleasant one and the mother's dominance can become bullying and have a 'grip over her' and there are issues with boundaries (Therapist Boann: p.8; Therapist Nemain: p.3) and parents and children can be very co-dependent in many ways (Therapist Nemain: p.3). The daughter may unsuccessfully try to set boundaries by attempting to remove herself from the relationship or to cut down on the amount of time spent with the mother but this may prove impossible Sometimes this is not possible because there has been the death of the father and she may feel that she is totally responsible for the mother (Therapist Boann: p.30-31).

MEMO EXCERPT: Reflective Piece: Enmeshed mother and daughter 30.11.17

The dynamic of the mother being dominant and the father being a peripheral figure in the daughter's life was highlighted by O'Sullivan (1979) as being a feature of the Irish family. Barnes (1986) found that the control over the daughter was virtually complete, even if it was subtle and well-intentioned, which brings back the idea of the daughter being very sensitive and internalising even subtle messages given by the mother in a very rigid absolutist way.

Analytic Strategies for theory development

The ultimate purpose of grounded theory is to use structured analytic strategies to build a theory (Corbin & Strauss, 2015; Glaser & Strauss, 1967). A theory is "a set of well-developed concepts related through statements of relationship, which together constitute an integrated framework that can be used to explain or predict phenomena" (Strauss & Corbin, 1998, p. 15). For Strauss and Corbin, analysis involves denoting concepts that stand for the analyst's interpretation of the data (Corbin & Strauss, 2015). The following section describes the Corbin and Strauss (2015) method of grounded theory analysis for theory development, which includes (a) open coding, (b) context and process, and selective coding (Corbin & Strauss, 2015).

Corbin and Strauss (2015) state that the use of computer programmes such as NVivo have become standard for qualitative research, but caution that it should not direct the research in terms of automatically organising or reorganising the data. For this study, the researcher utilised NVivo Software to store and manage the data. Given the large body of data collected, the use of this database software facilitated the open coding process, moving and merging text coded at themes and reorganising these lower level themes under higher level categories during the context and process stage of coding. The conceptual process of coding was exclusively conducted by the researcher throughout the analysis stages and was not supported by any of the advanced features of the software such as automatically coding data to identified themes.

Open coding. Open coding is the first stage of analysis in grounded theory and the procedure for open coding has changed little from the time it was originally devised by Glaser and Strauss (Kenny & Fourie, 2015). Open coding is defined by Corbin and Strauss as: "Breaking data apart and delineating concepts to stand for interpreted meaning of raw data" (Corbin & Strauss, 2015, p. 239). In Straussian Grounded Theory, information is broken down into pieces of data that are compared with one another and these lesser concepts are linked around higher-level concepts called categories (Corbin & Strauss, 2015). In order to do this, a line-by-line analysis is recommended; although line-by-line can also mean word-by-word or incidence-by-incidence (Charmaz, 2006). This procedure allows researchers to view the familiar in completely new ways (Charmaz, 2006) and ensures that all concepts and categories are supported by the text (Creswell, 1998). Categorisation privileges the data but is facilitated by previous understanding.

Codes denote meaningful pieces of data (Corbin & Strauss, 2015). Open coding has the advantage of identifying relevant concepts without speculating why they might be relevant. It supports the process of generating theory from the data by enabling the researcher to stick closely as possible to the data in the initial stages, as it is from these minute codes that the

theory will eventually be constructed. The process of coding begins by coding each incident in the data into as many concepts as possible, which represent behaviours that need to be explained. Concepts stand for interpretative meaning (Corbin & Strauss, 2015, p. 57). The first concepts are generally lower-level concepts but they may eventually turn out to be categories. However, the researcher cannot know this until later in the research (Corbin & Strauss, 2015).

Grounded theory is an iterative process, which goes between concept and data and constantly compares data sources to allow for the development of concepts and theory (Rowlands, 2005). The constant comparison method outlined in the original book by Glaser and Strauss remains a feature of all versions of grounded theory analysis (Kenny & Fourie, 2015). It involves the simultaneous collection and analysis of data and the construction of categories from the data itself, which gradually developed into a theoretical framework through a process of constant comparisons. The method begins by comparing incidences in the data to generate the theoretical properties of a category, integrating categories and their properties, deliminating the theory through a process of saturation and producing an analytic framework in order to form a substantive theory. Categories denote a major theme to which the basic-level concepts are pointing (Corbin & Strauss, 2015, p. 76) and these provide the explanations for the behaviours (Glaser & Strauss, 1967). The more incidences coded to the same node reveals different aspects of the same phenomenon (Corbin & Strauss, 2015). For example, the category 'Endless attempts at failed or painful sex' encompassed lower-level concepts that were developed in the open coding stage; 'Endless attempts at failed sexual intercourse,' 'Putting up with painful sex and 'No hope of resolving it.' The category 'Need to feel in control' similarly encompassed lower level concepts developed in the open coding stage; 'Vaginismus may have a personality type,' High standards of perfectionism are major drivers of behaviour,' 'Living in her head,' and 'Needing (protective) space.' A screen shot of

the NVivo database open coding final stage with fully integrated and saturated categories exported to Excel is available in Appendix I.

Context and Process. In order to go beyond description and to construct a theory that offers explanations, Straussian Grounded Theory moves to a higher-level stage of analysis known as context and process in the latest version of the Straussian model (Corbin & Strauss, 2015). Context is defined as something that "locates and explains action-interaction within a background of conditions and anticipating consequences…it links concepts and enhances a theory's ability to explain" (Corbin & Strauss, 2015, p. 153). Processes are defined as "adaptive changes in action-interaction taken in response to changes in conditions" (Corbin & Strauss, 2015, p. 153). According to Corbin and Strauss, both context and processes enable a theory to explain by enhancing our understanding of how actions can be facilitated or limited by conditions, which can be, for example, personal, environmental and/or cultural.

Context refers to the relationship between categories that capture the conditions that make up situations, how these conditions are interpreted by participants, the actions taken as a result of these interpretations and the consequences. These actions can represent a pattern of behaviour that participants use to achieve a goal or to solve a problem and this is known as process. Codes are synthesised in order to connect sub-categories and are more inferential than descriptive allowing for a more comprehensive explanation of an emergent theme or pattern (Rowlands, 2005). Codes, at this stage, may be reassigned to different categories (Elliott & Timulak, 2005). For example, the code *Vaginismus is a meaningful psychosomatic symptom* was originally under the higher level category of *Utilising therapy as a way for both partners to connect in the relationship.* However, this code was reassigned under the heading *Developing sexual self is experienced as confusing and threatening,* in order to encompass all of the information in that code, that incorporates the meaning of the psychosomatic symptom from early sexual development into the couple relationship and help seeking experiences. Corbin and Strauss recommend filling in fully developed categories to

give them density and variation but dropping concepts that are never fully developed because they do not appear frequently enough in the data and therefore contribute little to the understanding of the phenomenon (Corbin & Strauss, 2015). The raw data were reviewed again in the context and process stage in order to fully develop the emerging categories but some were not found frequently enough in the data to do so. Concepts such as *threats and ultimatums hinder resolution, sexual difficulties can be an issue for both partners, partner is unable to care for her emotional needs* and *understanding vaginismus as a spectrum* were not included in the final integration for this reason.

This stage of analysis produced the following eight higher level categories/themes under which the lower level categories were grouped. A complete list of the higher level categories and the sub-categories is included in the NVivo screenshot exported to Excel from the context and process coding analytic stage in Appendix J. Context and process are represented as events, within specific conditions, that leads to certain interpretations and actions that facilitates the development of vaginismus, the maintenance of the difficulty and its resolution. In order to frame events and indicate conditions, Corbin and Strauss recommend an analytic strategy at the context and process stage known as "Looking for Words that Indicate Time." Time-related words include: predate, when, if, since, after, before, start, begin, prior, never and ever. An analytic memo was written in which all incidences of these words were highlighted from the transcripts and written as a time narrative in order to frame the theory in a developmental sequence of the development of vaginismus from its earliest origins in the woman's life, through to the relationship and help seeking experiences. A selective piece regarding incidences of 'after' from this analytic memo follows.

ANALYTIC MEMO EXCERPT Aug 2019: Looking for Words that Indicate Time Example: Incidences of 'after' in the context of the theme of disconnection

And then when I was twelve, after that I got my first period. And my mam was like, "You're not using tampons…it goes gangrene if you leave it in for days," and that terrified me…It's heart-breaking. I mean, I think that is what started [vaginismus] all off" (Cliodhna: p.10). "…there wasn't anything too extreme in the past…why is it still there, you know what I mean? After all that time, after going through all the care, doing the research and it wasn't an extreme past, it was just someone telling you like, like her ma would have told her what she told her, how is it still existing as it was from the start?...I just think…obviously it's…it goes a bit down to mental…it's confidence…it's not just one or two or three or four things, it has to be a wide range of things...self-esteem and a bit of everything" (Ciabhan: p.21). "I would have been very conscious, especially in the beginning…I would know immediately like, the minute I would touch her internally…I would know myself to stop…after that I think it progressed pretty quickly and kind of went back to normal" (Curither: p.8). "I came back one day under anaesthetic and [the gynaecologist] came out afterwards and she said… 'even under anaesthetic you were extremely tight.' But then afterwards she said, yeah, em, "just kind of get over it." And those were her words…So that definitely sent me down a spiral" (Eva: p.3). "But I'm like [fertility issues] are terrible for you but I can't even get to that first point never mind like the stage after that…people don't understand that…I would never tell people that we have this issue, you know, I would say, "Oh we have fertility problems." So that's how I'd cover it" (Deirdre: p.7). "

Analytic Notes: After can be used as a marker, there is a time before and a time after when something changes.. <u>After getting her period</u> Cliodhna was told by her mother that tampons were dangerous and … she believes, resulted in her vaginismus. Her partner Ciabhan couldn't understand that <u>after all the time and all the care</u> that the messages could still have a

hold over his partner and control her behaviour. For Curither, after he understood what vaginismus was, he was able to anticipate tensing in the sexual encounter and adjust his behaviour After being examined by a gynaecologist, Eva was told to 'get over it' and the consequence of that was to send her into a depressive spiral.. Deirdre sees fertility problems as something that is a worry after the ability to have intercourse is sorted so all of her worry is on the lack of ability to be sexually intimate rather than having children.

Category Integration & Theory Development. In the final stages of theoretical integration, a core concept that expresses the main phenomenon of interest is developed by linking higher-level categories around a core category to form a substantive theory (Corbin & Strauss, 2015). Selective coding is the ultimate stage of categorisation and involves abstracting the results (Elliott & Timulak, 2005). The iterative process allows for the construction of broad categories (selective codes) and associated concepts that describe and interpret the data (Rowlands, 2005). In order to develop a theory, the identification of a core category is necessary. "A core category […] is the category among others that seems to have the greatest explanatory power and the ability to link the other categories to it and each other" (Corbin & Strauss, 2015, pp. 188-189). The core category must not only occur frequently in the data and be shown to grow in depth and explanatory power as each of the other categories is related to it but also be sufficiently abstract to be used as an explanatory concept, which ties all of the categories together in a coherent way (Corbin & Strauss, 2015). Category integration involves linking categories around a core category and refining and trimming the theory (Strauss & Corbin, 1998). In order to arrive at a core category, Corbin and Strauss recommend writing summary memos of both a descriptive and conceptual variety and to make use of integrative diagrams. The final overarching theme of disconnection and connection at many levels emerged from the process and context stage of analysis. An extensive analytic memo on the higher-level theme of disconnection was written. Three

excerpts from that memo are included below: Emotional disconnection from the mother, emotional disconnection from the father, Intimacy was not modelled in the home (parent's disconnected relationship) that eventually combined to make up the first sub-theme of the sub-core category 1: Protective Disconnecting: The developing self experiences a lack of emotional support from care givers.

MEMO EXCERPT: Interview Review Notes on the Theme of Disconnection and Connection Aug 2019

Emotional disconnection from the mother: "….we learn about intimacy in ourselves primarily from our mothers and I think we learn about how to manage our emotions from our mothers…and very often people have…their physical needs…taken care of, but their emotional needs have not been taken care of…when you don't know how to manage your emotions…you develop defence mechanisms…one of the defence mechanisms is somatisation…They are somatisers. And very often… you will find that the mummy…will listen to stories of ill health but they won't listen to any stories of emotional problems...there is no way of managing it; they don't learn how to manage it…if the mother can't manage a child's emotions then she can't help the child to manage either so that is just how things get passed on through the generations" (Therapist Fand: p.10-11). "If you have a type of parenting experience early on that has been, you know, either inconsistent or absent, and you take in something about yourself not being good enough…Something like that just kind of gets buried in there…How you fix that then I think is going about trying to…at an unconscious level….make reparations, fix that, you know, cover up for that, and fix yourself ultimately" (Therapist Bebhinn: p.9).

Emotional Disconnection from the Father: "the fathers are there…I don't know how present they are …there's not a huge amount said about the dad…grumpy men…typical man… the dad might be the head of the household bit, the mum's the one they talk to... she is

ultimately the one who has more control over what happens than the father has" (Therapist Bebhinn: p.11-12). "…her relationship with her father as the first significant man in her life, she was scared of him… he was just distant and hard, and not very affirming….he wasn't violent on anything….she didn't feel valued" (Therapist Danand: p.9-10). "…I know [my father] will talk about [sex] with his friends or with my mam, but he won't talk about it in front of us for some reason" (Cliodhna: p.12). "I'm just not very affectionate…my dad wouldn't be…we just don't have it" (Macha: p.3). "….mum was very volatile…and dad was very disconnected" (Eva: p.16).

Intimacy was not modelled in the home (parents disconnected relationship): "Often there is an absence of parental affection…It wasn't about being lifted up and being hugged…they would have known that they were loved and they would have known that their parents were proud of them but not in a demonstrative type of way (Therapist Etain: p.15-16) "…Some of them would never have seen any closeness or intimacy between their own parents at home… it wouldn't have been the warmest, affectionate relationship. So there is kind of an issue around intimacy because they wouldn't have had an experience of emotional, physical intimacy, observing it even as a child…very little modelling" (Therapist Eriu: p.4). "They would have been influenced by their mothers who were, again you are going back to a generation would have been more repressed. So some of their repression, they would have picked up from their mothers" (Therapist Danand: p.10).

"…I just think with my parents there was the thing of there was an awful lot of arguments at home, there was an ongoing thing…yelling and shouting…realising very early…say about eleven or twelve about intercourse that then I couldn't get my head around the idea that they would be, you know, arguing so much and then…I was thirteen when my younger sister was born…I found that all very difficult, you know, to kind of get my head around…contradictory…it didn't really fit in with what I thought made sense…I remember not really wanting to be in a relationship" (Niamh: p.27). "Maybe if my mam and dad were

together and they had an active sex life…maybe I would have a more positive view…my mum and my step-dad had a very active sex life…their relationship didn't seem very tender…you didn't see lots of chat and lots of messing or whatever…he was an aloof character" (Isolde: p.19).

In the selective coding stage, the eight categories that were developed in the context and process stage were integrated with one another to form three sub-core categories that, from a developmental point of view, indicate stages in the development, maintenance and resolution of vaginismus in the Irish context: This integration produced the core category that encompassed each of the sub-categories. A screen shot of the NVivo database selective coding final stage with fully integrated and saturated categories exported to Excel is available in Appendix K. Diagrams can depict the relationships between categories and contain only those categories necessary to capture the essence of the phenomenon under scrutiny (Elliott & Timulak, 2005) and are recommended by Corbin and Strauss (2015). Diagrams depicting evolution of the fully integrated theory representing the experience of vaginismus in the Irish context are available in the results chapter that follows.

Evaluation Criteria

Evaluation involves judging the way the research was done and the outcome of the research. Qualitative researchers have developed their own language to describe evaluative criteria for their research in order to delineate it from quantitative research as a distinct research approach (Creswell, 1998). Creswell (1998) suggests using the term 'verification' rather than 'validity.' Lincoln and Guba (1985) suggest using 'credibility' rather than 'internal validity,' 'transferability' rather than 'external validity,' 'dependability' rather than 'reliability' and 'confirmability' for 'objectivity.' This use of alternative language has a long tradition in grounded theory research. For example, from the very beginning, Glaser and

Strauss (1967) themselves used the term ‘credible’ rather than ‘valid’ as an evaluative term. This decision on language use reflected the philosophy that the outcome of research was not to find some objective truth but rather that the theory generated was believable by those who would read it (Corbin & Strauss, 2015). Grounded theorists take the responsibility for establishing verification as part of the research process (Creswell, 1998). In *The Discovery of Grounded Theory*, Glaser and Strauss specified credibility, plausibility and applicability as ways of judging the outcome of the study (Glaser & Strauss, 1967).

With regard to credibility, Glaser and Strauss (1967) suggest giving sufficient detail and description about the research process, how data was gathered and how analysis was conducted and to specify the kinds of data upon which interpretation sits, that readers can follow how findings and conclusions were arrived at. If this detail is provided then the theory can be accepted as one plausible explanation for the phenomenon, while also accepting that it is not the only plausible explanation. Plausibility concerns whether claims are likely based on an interpretation of the process of the research undertaken (Hammersley, 1991). Credibility refers to the likelihood that the researcher’s interpretation is considered to be accurate given the nature of the phenomena under investigation, the process of the research and the characteristics of the researcher (Hammersley, 1991). Glaser and Strauss (1967) deem a study to be both credible and plausible if multiple comparison groups are included, there is sufficient detail and description to give readers a sense of the process, there is sufficient evidence on how data was collected and analysis conducted so that findings and conclusions can be assessed. Strauss and Corbin (1998) distill these evaluative criteria into two. One criterion was the adoption of research standards appropriate to the particular study in question. The second was to provide sufficiently explicit accounts of procedures including sampling, coding, analysis and theory development so that readers could evaluate their appropriateness. This methodology chapter has outlined the research standards applied by the researcher to adhere to the Straussian version of grounded theory methodology and examples

of the procedures undertaken during sampling, coding, analysis and theory development. This detail allows the reader to evaluate the appropriateness of the researcher's interpretation of the participants' experience of the phenomenon.

Transferability (external validity) of the data is facilitated by providing readers and examiners with a rich, thick description (Creswell, 1998). Credibility is underpinned by trustworthiness and the ability of the theory to resonate with participants', researchers' and readers' experience of a given phenomenon (Corbin & Strauss, 2015). Lincoln and Guba (1985) consider trustworthiness as being the main criteria for evaluating qualitative research as it underlines the credibility of the research at every stage. Trustworthiness begins in the preparation phase and applies to the trustworthiness of the data collection method, including the sampling strategy chosen and the selection of a suitable unit(s) of analysis and continues through to the analysis and reporting of results (Elo et al., 2014). In order to ensure trustworthiness, Elliott and Timulak (2005) suggest the following: describing theoretical and personal interests in the research, describing the sample, providing examples of categories, organising categories to provide a coherent understanding of how they fit together, providing credibility checks, accomplishing general vs. specific research tasks and allowing readers to evaluate whether the categories resonate with the first- or second-hand experience of the phenomenon. If sufficient information is provided, it should allow for an experience of vicarious participation in the data collection and analysis process that allows for an understanding and evaluation of how the theory was arrived at (Glaser & Strauss, 1967). The methodology chapter and the results chapter that follows outline the stages of data collection and analysis along with excerpts from descriptive and analytic memos and providing direct quotations from participants to enrich the data with a rich, thick description of the phenomenon and to illustrate how interpretations were arrive at through the research process.

Elliott and Timulak (2005) suggest that one of the ways that the credibility (internal validity) of analysis can be evaluated includes validation by research participants with whom

the theory should resonate. In order to ensure fidelity, all participants had the opportunity to read over and comment on the accuracy the transcribed material (Kent, 2000). It is important to introduce a word of caution here, however, about involving participants in the evaluation of the theory itself as an addition check on verification. Glaser (2002) suggests that this is not recommended as an additional check because participants may not fully understand the theory or be able to appreciate how the description abstracts to a more general theory as they do not have the full data set at their disposal. Glaser and Strauss (1967) originally designed grounded theory analysis to break apart the data in order to avoid becoming immersed in any one story or perspective. Grounded theory is not the voice of any one participant but an amalgam of all of the data used for theory generation. Therefore, although participants were asked to verify the accuracy of the transcribed interview, they were not invited to contribute to the analysis or theory development stages.

In order to reach the criterion of credibility, research needs not just to be plausible but also applicable (Corbin & Strauss, 2015). Applicability means that "findings can be readily used because the findings provide insight, understanding, and work with diverse populations and situations to bring about desired change" (Corbin & Strauss, 2015, p. 346). Each branch of grounded theory values applicability as criteria for evaluating grounded theory analysis (Charmaz, 2003). From the very beginning of the study, the researcher has been dedicated to raise awareness and bring about positive changes for women and couples affected by vaginismus and to reduce the stigma that surrounds it. Throughout the study, efforts were made to apply the findings to situations that would allow for greater understanding vaginismus. As outlined above, various print and online media were utilised during the recruitment phase not only to raise awareness of the study but the raise a more general awareness and understanding of vaginismus among the Irish population. The researcher was also in touch with members of the Health Service Executive (HSE: the health service provider in the Republic of Ireland) about designing leaflets in conjunction with the HSE that could be

given to health care professionals and to women in primary care settings in order to provide accurate information on vaginismus and help-seeking in Ireland. This collaboration was postponed due to the COVID pandemic. The couples that took part in the study, if they had not resolved the issue, were offered referrals for counselling support.

With regard to applicability, Glaser and Strauss (1967) suggest that a theory should fit and be sufficiently general to be applied to diverse situations and populations, be readily understood and to provide sufficient means to bring about change in situations. "If it fits and it is useful because it explains or describes things then rigour and vigour and truth and everything else must have been built in to the research process or the findings would not hold up to scrutiny, would not explain situations, and would be invalidated in practice" (Corbin & Strauss, 2015, p. 346). Applicability, thus, fits well with the underlying philosophy of pragmatism (Charmaz, 2003). Lincoln and Guba (1985) suggest that it is not necessarily the responsibility of the researcher to transfer the findings to another situation outside of the original study but as long as the description of the study is sufficient to allow for comparison, applicability has been addressed. This chapter outlines the analytic strategies undertaken to produce a theory of vaginismus specific to the Irish context, providing a detailed description of the study to allow for comparison and evaluation.

Chapter Summary

Qualitative research not only encourages checking and auditing at each stage of the process, but many methodologies, including grounded theory, include specific strategies for doing so (Elliott & Timulak, 2005). To ensure credibility, Strauss and Corbin (1998) suggest the adoption of research standards appropriate to the particular research methodology chosen and to provide the reader with sufficiently explicit accounts of procedures to allow for their evaluation. This chapter has outlined the epistemological, ethical and methodological considerations of the study and how they were informed by the research question,

epistemology and aims of the study, as well as the internal checks that were made to ensure that the process undertaken adhered to Straussian grounded theory methodology and its symbolic interactive and pragmatic philosophical underpinnings. The chapter reviews the ethical considerations that were carefully examined prior to the commencement of the research and incorporated into the design of the study. The chapter has also outlined the sampling and recruitment methods, data collection design and procedures, analytic strategies for theory development and the qualitative standards by which the study can be evaluated. The chapters that follow provide rich thick descriptions of the findings of this research study to allow for the evaluation of the credibility, plausibility and applicability of a new theory of vaginismus in the Irish context derived from the data.

Chapter Four: Results

Grounded theory offers researchers a methodology to examine human phenomena from different perspectives, to uncover meanings, to develop comprehensive explanations of behaviour, and to build a theory that links categories around a central core category (Corbin & Strauss, 2015). The current study was concerned with gaining an understanding of the phenomenon of vaginismus among women and couples in contemporary Ireland. The overall aim of the research study was to build a theoretical model of vaginismus within an Irish context that can provide a greater understanding of the contributing factors and experiences of women and couples and how they attempt to cope with and seek help for vaginismus. It is hoped that a greater understanding of the experience of vaginismus will lead to enhanced approaches to treatment.

This chapter presents the key findings, identifying three underlying processes: protective disconnection, attempts at connection, and healing connection through relationships, that illustrate a core category, connection and disconnection. The core category explains the experience of vaginismus and help-seeking in the Irish context in a developmental process model. The context and process stage of analysis produced the following eight higher level categories/themes under which the lower level categories from the open coding stage were grouped: lack of emotional support from caregivers, pleasing others and denying emotional needs, sex is perceived as threatening and shameful, the sexual self is experienced as confusing and threatening, experiencing intimate relationships as emotionally challenging, accessing accurate information is hit and miss, experiencing the relationship as ways of reconnecting with disconnected aspects of the self, and experiencing therapy as a way for both partners to reconnect in the relationship. When discussing the content of each of these themes direct quotes from participants, both couple and professional, are included to illustrate the categories and the meanings that participants attach to them. The

categorical hierarchy that was constructed through the three stages of Straussian grounded theory analysis are summarised in Table 1.

Table 1: Summary of the Categorical Structure for Theoretical Development

CORE CATEGORY: CONNECTION AND DISCONNECTION

SUB-CORE CATEGORY 1: PROTECTIVE DISCONNECTION	
Higher Level Categories	**Lower Level Categories**
Lack of emotional support from caregivers	Emotional needs are not met
	Communication about sex is a no go area
	Perception of sex in the home is predominantly negative
Pleasing others and denying emotional needs	Very sensitive to shame and hurt
	Anxiety is extreme
	Puts the needs of others before her own
	Need to feel in control
Sex is percieved as threatening and shameful	Irish culture of silence and control of female sexuality
	Sex education in Ireland is inadequate
	Communication with peers about sex is isolating and shaming
The sexual self is experienced as confusing and threatening	Her body is not her friend
	I am the only one
	Vaginismus is a meaningful psychosomatic symptom
SUB-CORE CATEGORY 2: ATTEMPTS AT CONNECTION	
Experiencing intimate relationships as emotionally challenging	Endless attempts at failed or painful sexual intercourse
	Intimacy can affect and be affected by vaginismus
	Partner puts her needs before his own
Accessing accurate information is hit and miss	Medical professionals may not be adequately informed about psychosexual difficulties
	Referrals from doctors can add to the confusion
	Difficulty accessing services causes further distress
	Awareness of vaginismus is needed for greater understanding
SUB-CORE CATEGORY 3: HEALING CONNECTION THROUGH RELATIONSHIPS	
Experiencing the relationship as a way of connecting with disconnected aspects of the self	Relationships are sound despite the vaginismus
	Sexual in other ways
	A decision is made to resolve the problem
Experiencing therapy as a way for both partners to connect in the relationship	The therapeutic relationship can help with understanding and overcoming vaginismus
	Vaginismus can be more effectively resolved together as a couple

Protective Disconnection

The first sub-core category, protective disconnection, represents four of the higher-level categories: Lack of emotional support from caregivers, pleasing others and denying emotional needs, the sexual self is experienced as confusing and threatening, and sex is perceived as threatening and shameful. Protective disconnection, in the context of these themes, represents the action of disconnecting from emotional and sexual feelings and represents the woman's experiences prior to the couple relationship as described by the professional and couple participants.

Lack of Emotional Support from Caregivers

The theory of vaginismus outlined in this chapter finds its origins in early childhood experiences in the family of origin. The perceived lack of emotional support from caregivers in early childhood and adolescence was captured by the following three lower-level categories: emotional needs are not met, communication about sex is a no go area and perception of sex in the home is predominantly negative. This theory proposes that there is a lack of emotional connection within the family of origin, with few displays of affection, limited emotional communication and a lack of emotional support from parents. For daughters, the messages around sex from her family are often frightening with the intent of curbing her sexual feelings and behaviours to prevent shame being brought upon the family. Daughters may be socialised to perceive sexual behaviour as shameful and threatening not only to her reputation but the reputation of the family.

Emotional needs are not met. In most of the couple interviews the women shared difficult experiences of growing up in families in which they perceived their emotional needs were unmet. Relationships within the family were described by the women as being unaffectionate and emotionally distant. Isolde said of her parents, "their relationship wasn't very tender…you didn't see lots of chat and lots of messing," and her parents ultimately

parted ways. Niamh remembers a lot of arguments and shouting between her parents, and this led to a lot of confusion when her sister was born when she was thirteen because she could not imagine them being affectionate or intimate with one another. She said, "I found that all very difficult to kind of get my head around…contradictory…it didn't really fit in with what I thought made sense…I remember not really wanting to be in a relationship."

Many of the therapists interviewed said that their experience suggested that the parents of women with vaginismus did not model affection in the home. Therapist Etain said, "Often there is an absence of parental affection," while therapist Banba noted that her clients, "would never had seen any closeness or intimacy between their own parents at home…they wouldn't have had an experience of emotional, physical intimacy, observing it even as a child…very little modelling." The parents portrayed in the couple interviews did not frequently have an openly affectionate relationship with one another and were quite often very reserved. Sadhbh's parents lived with her maternal grandfather and gran-aunt who had "similar or more extreme views" about sex than her parents and so each generation of the household seemed to have a restrictive effect on the one that followed.

The picture of the father that emerged from the interviews was of a parent who was both physically and emotionally distant. Therapist Beibhinn described the fathers as, "head of the house, grumpy men." Therapist Danand said of the father of one of her clients, "he was distant and hard and not very affirming…she didn't feel valued." In terms of the couple interviews, fathers were quite often noticeable by their absence. Sadhbh, Niamh and Deirdre did not mention their fathers at all and, in the other interviews, the paternal figure was quite often described as either physically or emotionally distant. Three women described father figures as being unaffectionate. Isolde described her step-father as "aloof" and Macha said of affection between herself and her father, "…we just don't have it." Eva described her father, who experienced very poor physical health, as "disconnected." Isolde had been through a very painful experience of parental separation and her father had physically moved away to

another country with his new partner. Her mother had remarried a man who was emotionally cold towards his new wife and her children. She summed up her early experiences of men by saying "Men kind of let you down."

The women in the couple interviews frequently cited very difficult relationships with their mothers who were described as unable to support their daughter's emotional needs. In some of the interviews, issues with the mother's psychological distress were highlighted as perhaps being relevant. Difficulties in the background of the mother concerning sex and pregnancy, such as difficult pregnancies or births were highlighted by some of the therapists who were interviewed. Medical doctor Fand highlighted post-natal depression as affecting the ability of mothers to provide emotional support to their daughters. Cliodhna said of her mother, "she was very bad with depression and anxiety…you see it started off when I was born." Liadain remembers her mother as always having been extremely anxious. Eva stated that her mother had suffered from depression and psychosis.

Whatever the reason, the mothers of women with vaginismus were described as emotionally distant in the daughter's lives. As one medical doctor noted, "We learn how to manage emotions from our mothers…very often people have had very good caregiving…and their physical needs had been taken care of, but their emotional needs had not be taken care of" (medical doctor Fand). Therapist Danu said, "The amount of people that say to me, I never got a hug. I know I was loved…I was fed, I was safe, I wasn't beaten, I was brought to school and all that stuff was taken care of but I didn't get hugs." Therapist Etain said, "They would have known that they were loved and their parents were proud of them but not in a demonstrative sort of way." Five women described how, when problems arose for them, mothers often did not engage on an emotional level. Curither said of his partner Liadain's mother, "anything to do with trauma or a medical problem…she does tend to kind of try to kind of shut it away, as in ignore it."

In the experience of four of the women, their mothers expected them to handle adult situations in their teenage years, and they said that they attributed their problems with sex and vaginismus to the lack of emotional support from their mothers growing up. When Macha went to her mother because she was being inappropriately touched by a boy at her class, she did not receive any emotional or practical support and her mother told her to sort it out herself by going to the teacher. She said, “Looking back now, I kind of wish that she had understood how upset I was about it…I would just kind of wonder, would those experiences have led to [vaginismus] ….because they weren’t dealt with properly.” When Eva’s mother was having her own sexual problems because of her husband’s erectile dysfunction, she shared the details with her daughter. Eva said, “It probably definitely formed a negativity towards [sex]…she would never go to therapy I was her [confidante].” In the case of Medb, her mother brought her to a gynaecologist as a teenager because her periods had stopped due to anorexia. She felt traumatised by the experience of the internal examination, for which her mother was present. “She was aware of the eating problems…but she was quite logical…I felt actually that it was a bit of a punishment for not eating. So [my mother] was like, ‘There’s no reason, there’s nothing physically wrong so you better start eating’.” Medhb described the experience of the internal examination as, “my first sexual experience,” and said, “I would tie [the vaginismus] all back, I think, to the exam that the gynaecologist….that just seems to be in my head so that every time I have sex that just seems to be my experience.” For her, the experience was compounded by the perceived lack of recognition from her mother of how difficult this experience had been for her. Deirdre had very heavy painful periods and she was sent at fifteen to have a gynaecological examination. She said that she could talk to her mother and her mother would have been supportive in a practical way by sending her for the examination because it was something physically wrong to get sorted, but there was a lack of emotional support and even now if she tried to discuss it with her mother, “it would still be an awkward enough conversation.”

This experienced lack of emotional support was not confined to childhood or teenage experiences and persisted in adulthood. Therapist Danand suggested that because mothers are not comfortable with sexuality, “she will not have been able to give [her daughter] a relaxed attitude to developing in a way to become a woman, to be comfortable around her own body and [her] sexuality,” Therapist Nemain said that the women were not supported, “to evolve into their sexual selves naturally.” She elaborated:

> The energy of growing up well sexually is an incredibly delicate thing. And the energy of supporting young girls to evolve into themselves and to like their bodies and to appropriately introduce the time when being sexual with somebody or being sexual with yourself becomes something that needs support.

Some of the women interviewed said that they had attempted to speak to their mothers about their vaginismus as adults but, according one therapist that conversation is “always just a little bit odd…the mothers feel very uncomfortable about talking about it too” (therapist Beibhinn). When Eva’s mother found dilators in her bedroom she said, “Why are you even trying, you are not made for this [meaning sex].” Grainne said, “I think I might have mentioned [vaginismus] to sort of test the waters and see if we were at that stage where we could talk about it but…I think it made her a bit uncomfortable…I think I knew by the way she reacted that she didn’t particularly want any details.” According to two of the women interviewed, their mothers seemed to be more concerned with how the vaginismus would affect their daughter’s partner. “And how does Ciabhan feel about it?” (Cliodhna). “She would find it impossible to believe that a man could manage to keep away from you or manage to go any length of time without [sex]” (Grainne). After the initial disclosure, it was generally never mentioned again. “She didn’t really ask me ever since…I’m not going to tell her” (Cliodhna). According to Deirdre, the traumatic internal examination was never mentioned again by her mother and said, “…even now I wouldn’t bring it up,” and “I don’t even know why I brought it up in the first place.” Medb went back to her mother after the

interview to try to ascertain if her mother had understood how upset she was by the traumatic gynaecological exam in her teenage years had been. She did not get any sense that her mother had any awareness at the time or any awareness now of how difficult it had been. She said, “Unfortunately there is a lot of things that we don’t talk about.”

Communication about sex is a no go area. Limited communication within the family was noted by many professional participants. Nine therapists and one family doctor interviewed mentioned that there would be a sense of embarrassment around sex that pervaded the household and prevented any discussion with parents or sometimes between siblings. Two therapists noted that this was not always the case and very much depended on the family dynamic and the quality of the relationships.

One of the catalysts of this embarrassment occurred when scenes of a sexual nature came on television and the whole atmosphere of the room would change. Therapist Beibhinn said that stories about judgmental comments being passed or the television being switched off would be commonplace. For example, therapist Fodla said that one of her clients remembered her mother saying, “Turn that dirt off” even if the scene involved just kissing or holding hands. The women interviewed said that sometimes the television was just switched off, sometimes they all sat there in embarrassed silence, sometimes there was an additional comment from parents such as, “Oh Jesus, what’s going on in the world today?” (Deirdre), or being told to put your hands over your face (Cliodhna). Therapist Aine said that when the television gets switched off with no discussion:

> Everything to do with sex and sexuality would be forbidden, overtly and covertly. But they would have absorbed the message that it is wrong, we don’t speak about it, we don’t discuss it, we don’t ask questions, it is a no-go area.

In terms of the couple interviews, neither the mother nor the father discussed sex with their daughters. None of the fathers in the interviews had had a discussion with their daughters about sexual matters and mostly left that up to their wives. However, in the case of

Cliodhna, her father actually intervened to allow her to attend sex education classes at her school when her mother forbade it but yet would not discuss sex education with his daughter directly. In three of the cases, the fathers made statements to make their position on pregnancy or cohabiting clear to their children without inviting a discussion. Liadain said that when she was about to move in with her boyfriend in college, her father asked sternly how many bedrooms they had, and on being told there were three simply replied, "That's very good so!" And then he left it at that." When an older sibling told Medb's parents that he and his girlfriend were about to have a baby, the father communicated to the rest of the family that, "they were getting married and there's a baby on the way…we just didn't know what to think, this was obviously not a good thing." Liadain's father was more direct when discussing his concerns about her hanging around with boys and said of his own sister who had had a baby out of wedlock, "Look at your aunt, her life was ruined."

Some of the women felt that they could not bring up the subject of periods with their mothers at all. The experience is summed up by Liadain:

> When I got [my period] I didn't know if she would be angry…because I just didn't know anything at all about it and nobody talked about sex or puberty or anything, it was all so taboo…I thought she might be angry at me for drawing her attention to it or, as in like, coming into the room and sort of 'What do you expect me to do about it?'…or angry that we had crossed the line because we had talked about it.

Some mothers refused to discuss sexual matters with their daughters. Grainne said, "I would never have talked to her about sex or boys." Deirdre's mother never mentioned it, leaving it up to the school. Cliodhna's mother actively tried to hide any information about sex from her daughter, refusing to discuss it with her or to allow her to attend sex education classes. Mothers sometimes spoke to their daughters about sex or periods in a practical way but for some the discussion only added to the confusion. Grainne recalls, "The only thing she told me about menstruating was that she was after buying pads in the shop and said, 'I'll show

you these now. Em, I'm finished using them, your sister has been using them for a while, your other sister has just started using them and some day you will need them.' End of talk." Hearing that account, her partner Diarmaid commented, "It's like a riddle!" Medb's parents held a family meeting about sex when there was an unplanned pregnancy in the family that was so confusing that she had to go to her sister after the talk to ask her what it was all about. Macha remembered that her mother decided to read aloud from a book and said, "I can just remember sitting on the couch bawling while she was explaining everything that happens because she wanted to do it in the right way…she just kept going…I think she was horrified." Deirdre said that her father never spoke about sexual matters and her mother talked about periods in a very practical way, "And that is the very, like the very nature of them. They are very practical."

Perception of sex in the home is predominantly negative. The legacy of the messages about sexuality from the Christian Church was a feature of many of the professional and couple interviews. Fionn said that even though the power of the Catholic Church is waning in Ireland, families continue to pass on the messages to their children. According to therapist Etain, women are particularly vulnerable to these messages around the time of puberty.

All of the professionals interviewed, with the exception of consultant obstetrician and gynaecologist Saoirse and physiotherapist Anu mentioned negative messages regarding sex and sexuality in the homes of their clients. With regard to masturbation, messages included, "You don't touch your body, you don't explore, masturbation is sinful, wrong, etc." (therapist Aine), "That's dirty, don't do that, take your hands away from there," "Touching yourself is wrong," (therapist Fodla), "Don't touch yourself, don't look at yourself," (medical doctor Flidais). Therapist Cian said that often these messages came from the mother but clarified that it was more likely that both parents held the same views saying, "I assume when you have that moral stuff, that is jointly [from both parents], because if there was a difference of opinion [between the parents]...this lady would get two versions." Therapist Boann said that

sometimes, “hang-ups and resistance to sex…can be the views of the father.” Therapist Brigid recounted a harrowing story of a client that was caught masturbating when she was twelve years old by her father who dragged her downstairs and publicly shamed her in front of the family by saying, “dirty bitch upstairs interfering with herself!”

Many professionals referred to fear of pregnancy and messages about pregnancy from parents and in particular the mother designed to scare the young girl into abstinence. These messages include, “Keep your legs crossed!” (therapist Nemain), “You are a slut if you do this” (therapist Etain), “Don’t get this reputation” (therapist Danu), ”It’s disgusting, it hurts and you will bleed the first time” (therapist Eriu), “Sex is dirty, sex is wrong, it is only for making babies and that’s it” (therapist Fodla), “Don’t come home pregnant!” (therapist Danand), “If you got pregnant now it would be the worst thing in the world” (therapist Aengus), “You come here pregnant and I am going to kill you” (medial doctor Fand). In the couple interviews, messages to the women included, “You don’t come in here and tell me that you are pregnant or you don’t do this with boys,” (Cliodhna). Medb said, “It would have been nearly easier to come back and tell my parents that you had murdered somebody…I just remember feeling I could never come back and tell them I was pregnant…unless I was married.” The harshest of these messages implied that the girl would lose everything. This is summed up in the following quote from therapist Cian:

> Mother’s threat… “If you’re pregnant, don’t cross the doorstep there. You are gone, absolutely gone. And the girl is frightened of her life of her mother, which, when she goes to be sexual, she is in a battle between trying to have her natural desire to be loved sexually…her defence is vaginismus. It closes up so she never, ever…Not alone will she lose her mother’s love, she’ll lose her house, her home.

One very confusing aspect of this was the mixed messages girls were given over their lifetime about pregnancy. Therapist Eriu explains, “On one hand, it was your duty to have sex with your husband, but on the other hand, you know, giving the impression that sex was not a

pleasurable experience…and sinful…that you shouldn't be doing it, and that it is dirty." When she was growing up, Deirdre was told, "When you get married, that's when you should have sex…to have a baby…pleasure and sex were not equated to each other at all." Men can be painted as, "awful figures, couldn't be trusted" (therapist Boann), and the act of sex is a duty to your husband and you were to "Lie back and do it" (family doctor Ernmas). Liadain was told, "You are the one who'll become pregnant and he'll be long gone…so stay away from boys!" and "Boys can't help themselves." In her adult years, when discussing her vaginismus, Grainne's mother told her, "If you want to keep your man, you know, you have to have sex with him." Therapist Beibhinn suggested that, in some cases, women had not taken ownership of their bodies at all and it is difficult to persuade them to explore their own bodies because the belief is, "That's for the man to do." Many of the therapists said that, in their experience, often siblings also did not discuss sexual matters with one another either. When siblings did talk to one another, it was not particularly positive. Medb remembers, after a family conversation about sex that left her confused, asking her older sister but her description was, "She just told me the mechanics of what happens…quite disgusting…it didn't sound very appealing."

Five of the therapists and the physiotherapist interviewed highlighted the negative effects of viewing erotica or pornography in the home and the effect it could have on emerging sexuality. For Niamh, reading Mills and Boon books was a positive experience in terms of portraying romance but negative from the point of view that "they'd say there would be this moment of pain…I think in my head sometimes it's like a big deal, you know, the moment that when we'd be together, you know?" For Isolde, who saw pornography, the effect was more traumatic, "there was no joy…no tenderness…the lasting effect is …I can always see myself having sex, it's like I watch myself and it is just like, it's a fucking car crash…so then that's why I just can't."

Pleasing Others and Denying Emotional Needs

Within the context of the family relationships described in the previous section, the sense of self that develops early on in life is externally-focused on the needs of others and denying her own emotional needs. A picture of the emotional life of the young girl emerged, predominantly from the interviews with professionals, that was captured by the following four lower-level categories: very sensitive to shame and hurt, anxiety is extreme, puts the needs of others before her own and need to feel in control. These findings suggest that women with vaginismus may be more sensitive to the lack of emotionality within the household and to shame and hurt than her siblings, which can manifest as extreme anxiety. In order to protect herself from the anxiety, shame and hurt, her defence may involve increasing her feelings of control over, and disconnection from, her own emotional and sexual needs and putting the needs of others first.

Very sensitive to shame and hurt. With very few exceptions in the data, the woman with vaginismus was the only one in her family to have the difficulty. Despite growing up in the same household with the same parents, generally her sisters did not share this particular sexual difficulty. A number of therapists mentioned that women with vaginismus have internalised the messages in childhood in a particular way that produced a sense of shame and so these messages have affected them more than it did other members of the household.

> What they have taken in has been how they have heard it and internalised it, but it has been very harsh and critical. And I think if there is something like that, well then what may be taken as a…something that has a degree of flexibility is taken as an absolute. And I think there is probably something about that and the way it gets heard. (therapist Beibhinn)

This experience resonated with two of the women who were interviewed. Cliodhna described why she thought that her sister might not have had the same difficulty as her and

she simply said, "She didn't listen [to their mother] where I took it in." Her partner Ciabhan commented that, "it wasn't an extreme past, it was just someone telling you like, like her ma would have told her what she told her, how is it still existing as it was from the start." She responded, "It goes a bit down to…it's confidence." Similarly, Sadhbh said that she dressed conservatively whereas her sister wore whatever she liked even though they got the same critical comments because she, "had this sense of…you should do the right thing, you should do what you are supposed to do." Deirdre described her sister as "the wilder one" with more "liberal ways" and that her perception was that her parents were harder on her than on her younger sister. Therapist Cian was the only professional to mention that sisters in the same household can have the problem. He elaborated that both of the sisters in this particular case had a mother that was described as "an iron fisted mother," and "very controlling…she frightened them…both of them." In only one of the couple interviews (Macha and Cruinniuc) the woman said that her sister also had the difficulty but, in this case, the mother was not described as controlling or frightening but was experienced as emotionally distant and unsupportive. She did not disclose whether her sister had had similar perceptions of her mother.

Anxiety is extreme. In all of the professional interviews and in all of the couple interviews except one, extreme forms of anxiety were highlighted as being a concern for women with vaginismus. A number of therapists described their observations of women with vaginismus: "They are so anxious…that would be the extreme…if you were to talk by them in the waiting room, you would see how anxious they are" (therapist Banba), "She tends to be anxious, very uptight and you can see that visibly" (therapist Bebhinn), "Even when she is sitting there…tightening up" (therapist Boann).

This anxiety frequently manifests in the body as extreme forms of tension. Therapist Etain said of one of her clients, "Her emotional state very much came out in her body…she had pains in her back because, you know, anxiety…her stomach is just constantly like that.

And even, she would sit like [hunches over], you know?" Obstetrician and gynaecological consultant Saoirse said that the women are in, "chronic spasm…back, neck, shoulder issues...pain going down their legs and up their back." Physiotherapist Anu described a pattern of physical tension, "very high breathing…they like to clench, the abdomen is all pulled in." In the case of one of her clients, the pain radiated down the woman's thighs and legs making it difficult to stand and walk without pain. This tension can also extend to the vaginal muscle as described by family doctor Flidais; "that muscle that goes into spasm and is like a brick wall."

Sometimes, the anxiety generalised to all areas of life. Therapist Danu said, "Women who struggle with sexual pleasure and penetration….would usually have a worried or an anxious approach to life generally." Niamh said, "I just really find that I get overwhelmed with things in general." However, therapist Danand said that she had not found that the anxiety was necessarily generalised to other areas of life and was more often centred around sex. Therapists Aine and Nemain, family doctor Ernmas and consultant obstetrician and gynaecologist Saoirse mentioned that any contact with the genital area, whether to do with tampons, internal examinations or intercourse may induce a panic attack and phobic avoidance. Family doctor Flidais said, "they would have a heightened sense of privacy and a sense of self and not to want that self invaded."

Three therapists and one physiotherapist interviewed described the women as having anxious personality types but therapist Cian cautioned against describing the women in this way because it can be interpreted as something that cannot be changed. Therapist Nemain said, "the body doesn't go into that kind of tension on its own, it doesn't…we are born with a body that is usually intact and we learn along the way all the stuff that gets lodged in it." Therapist Banba said that growing up, women with vaginismus would have been worriers. Therapist Etain elaborated, "If you start looking at childhood, you can normally see a pattern

of anxiety, shy child, anxious." The extreme forms the anxiety could take in childhood is summarised in the following quote by Eva:

> When I was a kid I would vomit every day. I was a really anxious kid like and I do think because of that I was really really tense and I think I had tensed up every single bit of my body….I definitely would have gotten only an hour or two of sleep since I was a kid….If I did sleep I had nightmares constantly or night terrors.

When asked why she thought that she was so anxious as a child, she said: "I suppose mum was very volatile...like if I had done anything like dropped something on the floor…mum would just erupt and wouldn't talk to me for days…so I would say that was probably the big thing." When asked about her anxiety and vaginismus, Sadhbh said, " I think it was just the way I was brought up and anxiety and the way I was taught." Liadain said, "Everything I learned about anxiety, I learned from my mother, I learned at my mother's knee."

Puts the needs of others before her own. For some women, their role within the family did not change as they got older and they remained involved in their family of origin to a degree that their own needs were not being met. More often than not, the relationship with the mother and serving her needs in particular were mentioned. Two patterns of relationship with the mother were identified by the professionals; one of enmeshed co-dependency, and one of unmet emotional needs. Four therapists identified a pattern of enmeshment with the mother in the family of origin which persisted into adulthood. The other professionals were more likely to mention patterns of unmet emotional needs. Similarly, within the couple dataset, there were more incidences of the unmet emotional needs within the family rather than evidence of enmeshment.

The worries of the family may have been taken in by the women in childhood. Therapist Nemain described one of her clients as the, "problem solver within the family and had continued to maintain the role." Sadhbh said that she felt that, as the eldest, she was expected

to be a role model for the others and dressed and behaved in ways she felt her parents would have approved of. Deirdre said that she was expected by her parents to be ”more grown up” and “more perfect” than her siblings. Niamh and Deirdre said that, as the eldest, the message was just not to cause trouble. Both mentioned that the family may not have been particularly affluent and so the parents had their own worries and they felt that they should not create any more difficulty. The women in the study felt the need to disconnect from their own emotional and sexual needs and to put the needs of the family before their own, often employing strict moral standards and codes of conduct on their behaviour to avoid potentially letting down or shaming the family.

Need to feel in control. Feeling in control over emotions and behaviour was deemed to be very important for the woman with vaginismus by many of the professionals. Therapist Fodla explains it in this way to her clients: “Control is a defence mechanism and it was developed maybe in early life as a means of protecting you…so it worked then and it has gotten you where you are today….” Therapist Eriu said that feeling in control often has to do with meticulous planning and this resonated with Medb: “There would be some anxiety, em, yeah, I do like to plan and know what’s happening...” Cliodhna summed up this sense of needing to be in control in the following way:

> I like having my own control in everything…driving, cooking, everything. I don’t like having no control, I just, I feel like something’s going to happen….I’d love to be able to let go and say, “Oh, you just do it, it will be grand!

When there is increased sensitivity to shame and hurt, a sense of control can be increased by putting boundaries around her own behaviour so that she does not invite shame. According to the professionals, the woman often has high standards of perfection for herself that she imposes in a rigid way in order to protect herself. Therapist Fodla said that the woman will have done “the right thing all the way through life,” and “comes across as very diligent, very correct…starchy.” Therapist Beibhinn said that their behaviour will be dictated

by their perception of, “what nice girls do and what’s proper.” This is captured in the quote by therapist Etain who said that for women with vaginismus there is an, “element of sensitivity to shame, not wanting to shame themselves or their families in any way…or to be ridiculed in public in any way because of their behaviour…they are very controlled in behaving…within what would be socially acceptable norms.”

Therapist Aine suggested that because of the rigidity inherent in the approach to life, women with vaginismus need things to go in a particular way and when it doesn’t, for example during the sexual encounter, it becomes “confusing and distressing.” This is illustrated in the quote by Liadain who had a case of secondary vaginismus: “I felt like I should have been controlling it better. I couldn’t understand how I couldn’t control it and how, for my whole adult life, this had always worked fine and then it suddenly kind of breaks down.” Therapist Cian said, “The vaginismus not only protecting you against the pain but protecting against the failure, the vulnerability.”

Some therapists said that the experience of orgasm can also feel scary and out of control because they “are not in charge of their own body” (therapist Eriu), and that the act of sex is, “something that they can’t stop” (therapist Boann), and because of this anxiety “They may not be allowing themselves to become aroused” (therapist Brigid). Family doctor Ernmas described the experience of sexual intercourse for the women as ‘Entering into something that is not connected enough…you are not protecting yourself…you’re fragmenting part of yourself and someone is taking it.’ Therapist Aengus summed these feelings up in the following way:

> Under circumstances like that, where someone is in a sexual situation…and then suddenly they feel under pressure, they feel they have no control in that situation and their bodies are probably reacting and there is a sort of closing down fashion…’I can decide if I will or I won’t for a start.’

This experience is also captured in the couple interviews. Isolde said, "In terms of sex in general…I don't like that feeling of literally being pinned down…a lot of women see sex as a demand…it's not a request."

For a woman who is very sensitive, anxious, and not able to ask for what she needs, a sense of control can be an important defence to protect the self from the anxiety of shame and hurt. Sexual intercourse can be seen as a threatening situation where she feels totally out of control or that control has to be relinquished to another person. Some women may disconnect from their sexual feelings in order to protect themselves. This sense of threat may develop at a time when the sexual self is attempting to emerge, and certain experiences or messages within a particular cultural and familial context creates shame and anxiety. These themes are explored in the next section.

Sex is Perceived as Threatening and Shameful

The perception of sex as threatening and shameful at a cultural, familial and relational level was captured by the following three lower-level categories: Irish culture of silence and control of female sexuality, sex education in Ireland is inadequate and communication with peers about sex is isolating and shaming. There is a silence and shame that pervades Irish culture concerning matters of sex and sexuality, that can prevent sex being discussed in the family, with peers, and even within formal educational systems, that can compound the sense of isolation and shame.

Irish culture of silence and control of female sexuality. All of the professional participants mentioned Irish culture as being significant in the formation of shameful attitudes around sex and sexuality either historically or in the present day. Some indicated that historically we are very bad at talking about sex but that it is improving, but this liberal attitude did not necessarily extend to sexual dysfunctions such as vaginismus. For the majority of the therapists and medical doctors interviewed, a more liberal attitude around sex

and sexuality was not particularly evident from speaking with their clients about their upbringing. Irish culture was seen to be particularly strict with regard to sex and sexuality and an embarrassment around sexual matters as pervading Irish culture. Therapist Banba said, “The common thing would be the whole thing about sex not being talked about….there might be a lot of embarrassment…you are describing most of Irish society when you describe this.”

One of the aspects of Irish culture that came up in the interviews was the image of the Irish family and their sensitivity to shaming of any kind. Therapist Eriu said, “I am not sure other cultures cared as much about what the neighbours thought.” She further elaborated that if something happened that was potentially shaming to the family, the strategy of Irish families would be to, “close ranks really fast and keep it out of the public domain….that is part of our culture, there is a secrecy around it.” This sensitivity to shaming was also illustrated in the experience of many of the couples interviewed. Medb said of her parents, “The rules and regulations [of Catholicism]…what would the neighbours say…they would have been quite sensitive to all of that.” Macha said that her mother was “quite religious,” and when asked if that affected her mother’s attitude about her moving in with her boyfriend she said, “I would say it was part of it, but I would say it was partly to do with image. Like she wouldn’t want the neighbours knowing that my boyfriend stayed over.” Lir said of his partner Eva’s family, “Keeping up appearances… [speaking to his partner] Your mother is so concerned with how…[what would the neighbours think].”

Some of the professionals spoke about the link between church and state in Ireland as being significant in forming wider cultural attitudes towards sex and sexuality. Sadhbh and Fionn mentioned churching and women and baby homes as part of a legacy to shame and oppress female sexuality. Sadbh said, “some of the patients were institutionalised from a young age when their crime was that they had a child out of wedlock…Like it is such a relatively short space of time from a situation or a state where from a country we were going from putting people in isolation just for, it wasn’t, not really a crime, to a situation where it is

freely-available for people who are undergoing the situation now." Family doctor Ernmas said, "There was this lie down and do it for Ireland thing…women who were oppressed, especially when you go pre 1960s…[Ireland] in particular…good Catholic Ireland…girls were prepared to be wives… and men wanted a virgin." Sadhbh said that Irish cultural expectations historically have been that women are not supposed to have any desire for sex and are only supposed to provide it to satisfy their male partners and to have children. Some professionals acknowledged that Ireland is more liberal now than it was at that time. Consultant obstetrician and gynaecologist Saoirse said, "I think people are much more open nowadays in comparison to the 90s and 00s in terms of talking…it is part of the history that is important and some of the older women would perhaps maybe laughed before but now people are answering and speaking about [sexual dysfunction]."

However, the experience of a more liberal attitude did not always resonate in the couple interviews, many of whom perceived that a culture of silence still persisted with regard to sex. Sadhbh said, "sexual issues are still quite taboo in Ireland." Her partner Fionn said, "it is kind of my upbringing or a kind of cultural thing but [sexual matters] is not something that would really be discussed. Cliodhna said, "it is very hidden, it is really brushed under the carpet." With regard to sexual difficulties, Sadhbh said that Irish people, "if they come in with problems like that, they are nearly hiding under the table." Niamh said, "I would see testimonials online, some people, especially in America…some of them you know would be able to talk to their family…they are quite open about it. But it is a different kind of culture in America." Macha's partner Cruinniuc said, "Still as a country, we are still back in the 1970s, we just don't talk about [vaginismus]…The church still has a hold or an influence." Sadhbh and Fionn said that the inability to discuss sex was due to their Catholic upbringing. Fionn added, "Definitely [religion] has a psychological effect on people…because it is just like people are being dictated to for years" but also added, "Obviously our generation now would be less tolerant of the Catholic kind of ethos I suppose because their presence is waning

regarding teachings and stuff." Sadhbh said of the legacy of Catholicism, "I think people's instinctive kind of gut feelings are still like, a woman, having sex, shame." Deirdre said that her Catholic upbringing led to believe that, "[sex] was to have a baby, pleasure and sex were not equated to each other at all." Couple Liadain and Curither said that sex was not spoken about in the home and both commented that their families were, "Way too Irish Catholic."

Medical doctor Fand, rather than discussing the role of the church, spoke about the effect of the Troubles in Northern Ireland on the Irish psyche. She said, "Patients that come to me with vaginismus have had soldiers tramping through their houses in the middle of the night on many, many occasions…very traumatic. And it is going to affect your sense of self and your privacy." Family doctor Flidais said, "It is the same whether you are Protestant or Catholic….I think the experience is all the same because [vaginismus] is a human thing…it is not just a cultural thing." Rather than attitudes towards sex and sexuality being an Irish cultural thing, it was more tied to fundamentalist religion. Therapist Beibhinn said, "It would surprise me if there is any culture where [vaginismus] is particularly absent." Therapist Cian said, "…could be Catholic, Protestant or Jewish, whatever…extreme religious influence."

Sex education in Ireland is inadequate. According to Therapist Boann, one way in which religion may have had an impact on attitudes to sex and sexuality was the control that the Catholic Church had over all aspects of education, including sex education. Therapist Danu said that, after religious messages, "lack of education is the biggest thing." All professional participants, with the exception of therapist Brigid and medical doctor Fand, said that their clients would have mentioned the paucity of sex education available. Therapist Aine called poor sex education "a very strong factor" in vaginismus and therapist Banba said "across the board, [sex education] wouldn't be [in the client's history]." According to therapist Nemain, in order to teach sex education, you have to be "reasonably grounded in your own sexuality," but the teachers expected to cover sex education in their schools also come from the same background and therapist Aine added, "they are certainly going to avoid

[talking about sex]. And so the impact goes on and on." According to therapist Cian, in Ireland, "there isn't good sex education, there is avoidance education." In Catholic Ireland, many of the teachers were celibate nuns who, according to family doctor Ernmas "had no idea, and the thing is if you sat on a lad's knee you would be pregnant." According to therapist Danand, "Some people mistakenly think this is a problem for older people, this can be a problem for still quite young people."

All of the couples interviewed remembered either a purely mechanical description of sex or, in some cases, no mention of it at all. They described it as, "a tick the box exercise," (Fionn), "mortifying," (Grainne), "It was certainly the biology, the mechanics" (Eva) "chastity and all this kind of stuff" (Lir), "It was about procreation and not like about any kind of pleasure or whatever" (Deirdre). Therapist Aine said, "I really do think it is time for our sex education programmes to change. It is past time for that." Many professionals wanted to see sex education taught in schools at an earlier age and an emphasis taken away from the biological aspects and towards relational aspects and to teach children life skills. Therapist Danu said, "we need to teach empathy, respect, boundaries and communication skills." Therapist Eriu said that, with regard to sex education, "parents have a responsibility too," but many parents do not take on this responsibly and she said that they certainly wouldn't describe sex as pleasurable to their daughters for fear that they would encourage promiscuity. Therapist Etain said, "You see patterns of people who haven't had good sex education…the people we see haven't had good formal education or good informal education." Family doctor Flidais said, "They have been so indoctrinated…I'm sure that the mother is not doing that deliberately to damage them, but the messages are there and they are internalised and it can be very hard to get rid of them." Therapist Boann said that a good formal sex education may have had the ability to offset messages in the home saying, "You wonder could a liberal open sex education in school, could that have superseded her mother's messages…she could have went, "Oh, you know, my mother's actually wrong about that." However, for most clients,

according to therapist Aine, "there has typically been very poor or no sexual education in school or none at home," and so there is nothing provided in schools that can offset the messages in the family of origin. Therapist Boann said that with regard to sex education:

> A big thing would be that kind of I suppose linking emotions with sex… and linking love with sex, you know? I think I think that is going to…that is a good guide rather than saying, Don't do it, it's wrong! It is more like, Well when it feels right, when you feel love and you feel that that love is back to you. I suppose explaining it through… and let their emotions guide them rather than this sense of a rule or right and wrong.

Macha said, "I keep coming back to was it the way I was brought up…that [sex] was never spoken about...almost like a dirty thing." Deirdre said that her Catholic background led her to see sex as a "dirty topic."

Communication with peers about sex is isolating and shaming. The silence and shaming around sex quite often extended to peer group interactions. Many of the therapists mentioned that most of their clients would not have spoken to their friends about sexual matters in any meaningful way. Eva felt that she couldn't keep up with her peers saying, "Teen years were highly sexualised years among my peers and I just, I couldn't relate to that…I could never see myself as that." Some of them would even pretend in company that they are having sex, or would just keep quiet when sex is brought up, for fear of being shamed by their peer group. Couple Deirdre and Naoise said that they would lie to their friends about having fertility issues when asked why they didn't have children because they felt that that vaginismus would not be understood, nor met with empathy, whereas fertility issues would.

If the women do manage to talk about sexual matters to their peer group, the messages were often frightening. Therapists Aine, Eriu and Bebhinn discussed the concept of "myths" about sex that develop through conversations with peers. The professionals' clients often

brought up stories of bleeding or pain in their sessions. They would recount that their peers would describe the experience of the first time by saying things like: “Oh I tried and it was really painful, and it hurt so badly…oh the pain was terrible!” (therapist Aine), “a friend of hers, who told her on her honeymoon to cancel all activities because she would be so sore she wouldn’t be able to walk” (therapist Banba), “I bled the first time…I didn’t really enjoy it” (therapist Eriu), “[the hymen] explodes inside you!” (family doctor Ernmas). Sadhbh said that her friends had said that, “[penetration] had been very difficult, the first time it had been painful.” Therapist Beibhinn summed up these experiences of peer interaction saying,

> And then getting to the stage where they think they ought to know things and, you know…and then reinforced by all kinds of myths out there about how sex should be and how relationships should be and what you should be doing, you know, and I think that further traps people into feeling very abnormal and being very ashamed and seeing themselves as failures.

Six of the women in the couple interviews had never mentioned the vaginismus to their friends. One of the issues with disclosing to a friend is a sense of betrayal of the privacy of the relationship. Half of the couples felt that if they were to tell someone, people would find it hard to understand why a couple can’t have sex when they perceive it as an easy natural process. Deirdre said that she perceived that people’s attitude would be, “What’s wrong with her like? It is not just put it in and away you go like? And you can try and understand it…you couldn’t really understand what it’s like to live it.” Niamh said that she felt that her friendships with other women had been affected because she could not speak to them in any meaningful way.

Cliodhna said that it actually might make it worse to tell people and have “everybody knowing and comments being made.” Niamh said that, “People just wouldn’t understand and then would be judgemental.” If the women try to speak to a best friend about their vaginismus, it is not always met with empathy. Eva said that when she told her female

friends, “There was a lot of laughing at it kind of like because they said that they hadn’t experienced it themselves…and more maybe just awkwardness.” In contrast, when Eva told her male friends, they reacted with much more sympathy. Her partner Lir interpreted this gender difference by saying that there has, “always been an element of kind of nearly female suffering in relationships.” In the interview, Eva and Lir spoke about women sharing stories of childbirth and suffering as a general theme of female conversation so that if someone has a problem, there is no empathy, “that’s par for the course,” and “we all went through it.” Therapist Etain said that, “We owe it to other women, we should help them and actually other women can be very harsh with women…everyone has to be the perfect woman,” sometimes this is because they can’t understand the problem because it has never been an issue for them.

However, Grainne, Eva and Liadain had spoken to their friends about their vaginismus and had been met with sympathy even if they could not empathise or understand. Liadain said, “She was just concerned for me and trying to help me…She couldn’t understand what was happening to me. She couldn’t personally empathise with me or put herself in my place.” She explained that, from her friend’s perspective, “It was like somebody telling you a story about something that happened in a different time.” Grainne was given a recommendation for a therapist when she told her friend who worked in healthcare. She also chose to tell her closest friends that she was taking part in this research study to raise awareness of vaginismus and, “they were just a bit intrigued ….kind of feeling a bit sorry for me that I had suffered…I didn’t go into any great detail.”

The Sexual Self is Experienced as Confusing and Threatening

As mentioned in the last section, puberty can be a very significant time during which the experiences that contribute to the development of vaginismus might occur. This is a time when the sexual self is developing, but when there is little emotional support this time of development can be experienced as confusing time and the sexual self as threatening. This

was captured by the following thee lower-level categories: her body is not her friend, I am the only one, and vaginismus is a meaningful psychosomatic symptom. Her body is not her friend describes the disconnection that women with vaginismus may feel about their own bodies; not wanting to look or touch their bodies and in many cases associating the body with shame and pain. Because of the lack of communication about sex, women may feel like their bodies are abnormal and when there is a problem such as vaginismus they are the only ones who are experiencing the problem, which can negatively impact on their self-esteem. The meaning behind the physical spasm was identified by couple participants and professionals as psychosomatic.

Her body is not her friend. Her body is not her friend is an NVivo code that was coined by Therapist Aine in order to describe the anxiety and the reluctance for the woman with vaginismus in her teenage years to touch, to look at, or to explore her own body. Six of the therapists interviewed commented on the women disconnecting from their body. Therapist Nemain described the lack of connection to pleasurable body sensations as, "unable to be alive in the body." Therapist Danu said that one client described it as, "I'm dead from here down…I don't even want to know about my body from there down." Eva said of her own body, "It was an area that almost didn't really belong to me, like it was a real disconnect."

Due to experiences in childhood and teenage years, a perception of the body being broken can emerge. These experiences include the lack of exploration of their own bodies, having painful conditions, experiences of gynaecological exams or experiences with attempting to insert tampons. Without exception, all of the professionals interviewed said that, in general, their clients would not have really spent any time looking at or touching their own bodies. Therapist Beibhinn commented on the lack of curiosity regarding her own body that often prevents women with vaginismus from touching or exploring. Therapist Banba said that, "[the women] would say that they think [touching or looking at their genitalia] is a strange thing to do….that it is not normal to be doing. So they would find it very hard to do."

In terms of the couple interviews, all of the women who described being comfortable exploring their bodies as teenagers had the secondary type of vaginismus, apart from Macha. All of the other women who had primary vaginismus said that they would not have felt comfortable exploring their own bodies. Sadhbh, Niamh, Deirdre and Medb said that they did not remember having much curiosity about their bodies and wouldn't have really ever thought about looking or touching. Medb said, "I wouldn't have really known my body, no."

Therapist Eriu said that, apart from a lack of curiosity, there can also be a sense of revulsion about the body. She said, "they feel that it is disgusting….they just don't like the idea of feeling the inside of their vagina…some of them are squeamish around their sexual organs." This resonated with some of the women in the couple interviews. Eva said of her genitalia, "I was actually repulsed by it." Cliodhna said that if she had to touch her own genitalia, "I would probably cry…squirm…I just don't like the feeling of it."

When women have not explored their own bodies, one consequence of that is having a perception of the body being abnormal. Women might not even be aware of where their vulval region is actually located. Many of the professionals highlighted the distorted view their clients may have of their bodies saying things like, "That part of me doesn't work" (therapist Aine), "Mine is not normal" (therapist Brigid), "It's far too small" (medical doctor Fand), "I can't have sex because I am damaged" (therapist Etain), "It's like a brick wall" (family doctor Flidais). Eva said that the vaginal muscles were like a "wall" and she began to wonder, "Is that even there? Have I an opening?" Her partner Lir said, "To a certain extent it almost felt like you didn't have a vagina." Deirdre said, "It felt like I physically didn't have an opening in my vagina…and that's the way it has always been."

Therapist Eriu suggested that another reason a woman might disconnect from her body was that they have experienced actual pain conditions and associate pain with the genital area of the body. Therapists Eriu and Danand, family doctor Ernmas and consultant obstetrician and gynaecologist Saoirse said that many of their clients would had had painful periods or

endometriosis. Deirdre, Eva and Liadain had painful periods. Niamh had polycystic ovarian syndrome. In the case of Medb, her periods had stopped due to anorexia. Therapist Brigid and Boann, medical doctor Fand and physiotherapist Anu mentioned that some of their clients with vaginismus also had autoimmune problems and chronic pain. Eva, in addition to painful periods, had fibromyalgia since childhood and Liadain had painful periods and irritable bowel syndrome. Physiotherapist Anu said, "[vaginismus] is the least of their bothers because…they have pain everywhere…and they generally don't tend to be sexually active because they are just not able for it." Therefore, the body may be associated with physical pain because the women are experiencing painful conditions.

In addition, the majority of the professional participants highlighted the role of difficult, impossible or traumatic smear tests or internal examinations experienced by their clients in the experience of genital pain and role this might play in the subsequent development of vaginismus. According to therapist Beibhinn, her clients were "generally very traumatised," by their experience of smear tests.." Most of the women spoke about their difficulties with routine smear tests. Macha had never gone for a smear test. Sadhbh and Niamh had gone more than once to have smears but could not tolerate the speculum. Grainne said that, "I had always found, like I would nearly faint at having a smear test…I didn't know what to expect…I was thinking why does nobody tell you these are so painful?" Both Isolde and Liadan directly attributed their experience of painful smear tests to the development of their secondary vaginismus. Liadain said, "Like the smear test you are kind of trapped and you can't…it doesn't matter if you back up the table, the wall is going to [trap you]…so I was a bit overwhelmed." Difficult experiences with smear tests can also confirm a woman's belief that her body is abnormal. Therapist Aine said that when smear tests are not possible, "it stands to reason that they would think, you know, that I am closed off in that area."

In the couple interviews, some of the women spoke about gynaecological issues and medical examinations in teenage years that were traumatic and painful. Cliodhna, Medb and

Eva were sent for internal examinations as teenagers and the gynaecologist's abrupt manner added to the trauma. Cliodhna said of the gynaecologist, "She was very rough with me….and she didn't really have much patience." Eva said she was put under anaesthetic on two occasions because the gynaecologist couldn't examine her and afterwards the doctor said, "Everything seems fine but even under anaesthetic you were extremely tight…Just kind of get over it…No solution…So that definitely sent me down a spiral." Deirdre and Medhb had had traumatic experiences with internal examinations in teenage years and never again went for routine smear tests. Deirdre said of her first experience of a smear test, "I was really terrified…there was no way that they were going to get near me." In the case of Grainne, a treatment to remove pre-cancerous cells in her cervix in adulthood and a concurrent regular occurrence of cystitis were attributed to causing her secondary vaginismus.

For some women, the perception of the body being broken or abnormal may be linked to failed or traumatic attempts to insert tampons. Some of the professionals mentioned that, in their experience, typically women with vaginismus would either not have ever tried to insert tampons or had traumatic experiences of attempting to do so. Cliodhna, Niamh, Deirdre and Macha did not attempt to insert tampons. Medb and Eva attempted it, but were not able to insert them. Therapist Beibhinn mentioned that the mothers will not have approved of the use of tampons and this resonated with the experiences of two of the women Cliodhna and Eva, who were forbidden to use tampons by their mothers. Both Cliodhna and Niamh said that they told their partners that they already knew that they were unable to have penetrative sex at the beginning of their relationship based on their inability to insert tampons.

I am the only one. The majority of the professionals interviewed mentioned that most of their clients would believe that they are the only ones who have vaginismus. They typically had never heard of anyone else with the difficulty, and frequently had never heard of vaginismus until it is mentioned to them by a healthcare professional. Therapist Danand said, "They would feel like they are not a normal woman, they are not like everyone else,

something that seems so easy for everybody else is so difficult for them." Sadhbh said, "If you think about it, you are never the only person experiencing a problem, but I suppose at the time, I had never heard of anyone else who was unable to have sex." Deirdre said, "It is a very lonely condition." The loneliness and shame of feeling like they are the only one with the problem can be exacerbated if they encounter a family doctor who is not knowledgeable about vaginismus. Sadhbh said that she left her family doctor's office feeling that she was, "relatively unique in having this problem."

Many of the professionals commented that carrying the shame of having a difficulty that she believes no one else has, and that this difficulty was her fault can negatively impact on self-esteem. If she is in a relationship, she can experience intense guilt and puts all of the blame herself. Therapist Boann said that, "women would feel that they were carrying the problem because the problem was lodged in their body." Therapist Etain clarified, "They recognise it as a couple problem but if you are looking to apportion blame…[the women] will come in and say it is a problem within the relationship but it is my fault." Therapist Danu stated that the women's biggest enemy is negative self-talk. Many of the professionals said their clients say of themselves, "You're useless and you're no good," (family doctor Flidais), "There is something wrong with you" (therapist Eriu), "I am not good enough…I don't deserve sex" (therapist Brigid), "I didn't actually feel that I deserved to be happy" (therapist Aengus), "I don't want to land [my partner] with somebody who's not right" (therapist Etain). Two of the therapists commented that low self-esteem will go all the way back to childhood because when parenting has been inconsistent or absent, "you take in something about… you're not being good enough" (therapist Beibhinn). "And that can carry right on into adulthood and can mean that they have very low self-esteem and that they are not able to enjoy their sexual experience," (medical doctor Fand).

In the couple interviews, the women spoke about the isolation and shame that they felt because they believed were the only ones who were experiencing vaginismus. Cliodhna said,

"I can't do that and I can't do this…Some nights you sit at home and you cry and you think to yourself, oh why does it have to be me?" Eva and Deirdre spoke about how vaginismus had affected their sense of self as women, as sexual beings and as partners. Eva said, "The main thing I've always felt is…I don't feel like a woman," and "I just never kind of connected with I am a sexual being." Deirdre said, "There are definitely times when I don't feel normal…and I feel like I'm not a proper wife…I feel undervalued as a person in that I can't [have sex]." Liadain, Niamh and Eva spoke about the effect vaginismus had on their self-esteem and self-confidence. Liadain said about her vaginismus, "It affected me really badly in terms of my view of myself and my self-confidence." Niamh said, "It has just reached the point where I think well no matter what I do in my life, that there is this issue that I haven't resolved and it is something I should be able to fix and I can't." Eva said, "There is the actual you can't have sex part and there is also the knock-on effects to your own self-esteem and anxiety and things that spill out into every other kind of aspect of your life…it is far-reaching." Isolde, Deirdre and Eva spoke about their guilt with regard to their partner not being able to have sex because of what they perceived was their problem and their fault alone. Isolde said she felt, "this constant state of pressure," Medb said, "that's my guilt…I would worry that we would just grow further apart," Eva said, "you feel like if Lir was with someone else he would be fine…intense guilt…lots and lots of guilt."

Vaginismus is a meaningful psychosomatic symptom. All of the professionals and couples interviewed recognised the psychological component of vaginismus as a meaningful psychosomatic symptom that repressed and sought to protect the woman from physical, psychological and emotional distress. Participants described how the emotional component of anxiety and distress can be repressed and somatised into a physical symptom. Medical doctor Fand said the goal of psychoanalytic therapy is to understand the symbolism of vaginismus saying, "Understand what this is all about for you, what this is a symptom of, what your body is trying to say to you about the whole of your life." According to some of the professionals

for some women, vaginismus represents a general fear of intimacy. Medical doctor Fand said, "They become blocked to intimacy, that's the whole point isn't it, about vaginismus… intimacy in general to me is more important than physical intimacy…but the whole person and how the whole person relates to the world is what really matters." In three of the couple interviews, the women noted difficulties with affection that predated their vaginismus. Niamh and Oisin said that they understood vaginismus as a psychosomatic symptom stemming from Niamh's fear of intimacy. Niamh traced this back to the volatile relationship that she had seen between her own parents in childhood. In the case of couple Macha and Cruinniuc, there weren't many other forms of physical intimacy in the relationship beforehand because Macha said of herself, "I'm just not very affectionate…I wouldn't be forthcoming with hugs and kisses." Isolde's and Tristian's lack of intimacy had predated and contributed to the development of secondary vaginismus. Tristian said, "[Sex] was so infrequent anyway…I didn't know there was…vaginismus."

Some professionals further commented that vaginismus may be a psychosomatic representation of difficulties in the relationship such as issues around trust and consent. Family doctor Flidais said that it is important to ask the woman, "Is there violence, is there coercion?" Therapist Boann suggested that vaginismus could be understood as the ultimate protest against a patriarchal society. Medical doctor Fand stated that, "Vaginismus is sort of saying no to something," These statements resonated with Isolde, her vaginismus represented for her a protest against being pressured to have sex as a marital obligation. Seeking help for the vaginismus she said, "Smacks a bit of …get yourself fixed and, you know, do your job." She had also had experiences of her partner being rough in the sexual encounter. However, none of the other professionals and none of the other couples interviewed indicated that there was a link between the vaginismus and serious relationship difficulties. The professionals said that couples experiencing vaginismus typically had very sound supportive relationships and that vaginismus was generally not indicative of deeper relationship problems.

Therapist Boann said vaginismus could represent, “a lodged trauma.” Medical doctor Fand further suggested that the idea of the vagina being too small may symbolise something childlike and may represent unresolved relationship issues in the family of origin and a reluctance to enter the adult world. Although a reluctance to grow up was not evidenced in the couple interviews, many of the women spoke about unresolved trauma in the family of origin. For some of the women interviewed, their vaginismus represented a protective defence mechanism against all of the frightening messages about sex they had received in childhood. For Deirdre, her vaginismus was a reaction to reading about a story of rape in a magazine as a teenager and the frightening comments that her mother had made to her about it such as, “Oh wouldn’t that be awful if that happened to you?” This experience had a profound effect on her. She explained:

> For years, I have always had this terrible sense of, like, I’d hate if I got raped…I think the vaginismus sometimes is a defence mechanism if someone tried to rape me…that’s my own personal defence if something like that happened to me.

She also said that her vaginismus represented a fear of penile penetration that stemmed from the negative messages about sex in the family of origin; of sex not being pleasurable and the terror of pregnancy. For Sadhbh, her vaginismus represented, “a deep seated fear of getting pregnant...it wasn’t the right time.” In the only case of situational vaginismus that emerged from the interviews, Macha and Cruinniuc were able to have sex when they lived abroad for a gap year and were away from their families but found it impossible when they came back home to Ireland.

For the women with secondary vaginismus, Grainne, Isolde and Liadain, the vaginismus represented protection from actual physical pain associated with the genital area. Grainne and Diarmaid said that two experiences contributed to the development of vaginismus. The first was an invasive procedure the woman had gone through to remove precancerous cells in her vagina. Diarmaid said, “It was the following year that it had become an issue…it seems like a

reasonable supposition." The second was recurrent bouts of cystitis that set up a cycle of pain and Grainne said, "you'd get a dose of that and then it would all be fine again for another while…psychologically that is the only link I can make really between this happening and the vaginismus, that it just became so hard to relax." Isolde also attributed two experiences to the development of secondary vaginismus. The first was an incredibly painful smear when a plastic speculum was used instead of a metal one that she described as, "fucking agony…they are really really painful," and the other was experiences of sex with her partner that were a bit rough, "there were a couple of painful experiences during sex…that made it kind of clench up…to protect oneself." Liadain attributed the cause of the secondary vaginismus to, "a traumatic smear test…inserted [the speculum], couldn't get it in properly and were like digging and digging…I know like vaginismus doesn't just appear out of the blue so I think it was possibly that…never had any problems really before that."

Medical doctor Fand advised that she tells her clients, "It is no wonder that you have had difficulties with your sex life considering such and such has happened to you….they can begin to understand that anybody in those circumstances would have had the same difficulties." Although patterns can be identified, the data suggests that the development of vaginismus predates the couple relationship and is a complex mixture of experiences that will be unique for every woman who experiences it. Eva said, "I think vaginismus would have happened to me with any partner, no matter what….I don't think I have ever had a time without it growing up." Liadain's partner Curither stated that it is important for partners to know that they did not cause it but can help to resolve it.

Protective Disconnection Section Summary

A pattern of experiences that predate the relationship can be identified in the data as perhaps being significant in contributing towards the development of vaginismus. In the family of origin, emotional communication can be restrictive and parents may be unable, for

various reasons, to care for their daughter's emotional needs in general, and particularly her developing sexual needs around the time of puberty. The daughter may deal with this by denying her own emotional and sexual needs and focusing on pleasing others. Not every girl in the household will develop vaginismus and those who do seem to be very sensitive to shame and hurt and experience intense feelings of anxiety. This overwhelming emotional state can manifest as extreme tension in the body in general and in particular the genital area. Feelings of shame, especially around sexual matters, may be dealt with by increasing her own sense of control over her environment and frequently over her own behaviour including her sexual desires and her own body. Her lack of knowledge about her own body combined with negative experiences of experiencing bodily pain, her inability to insert tampons, or early traumatic gynaecological experiences can lead her to believe that her body is broken and that she is the only one with the problem.

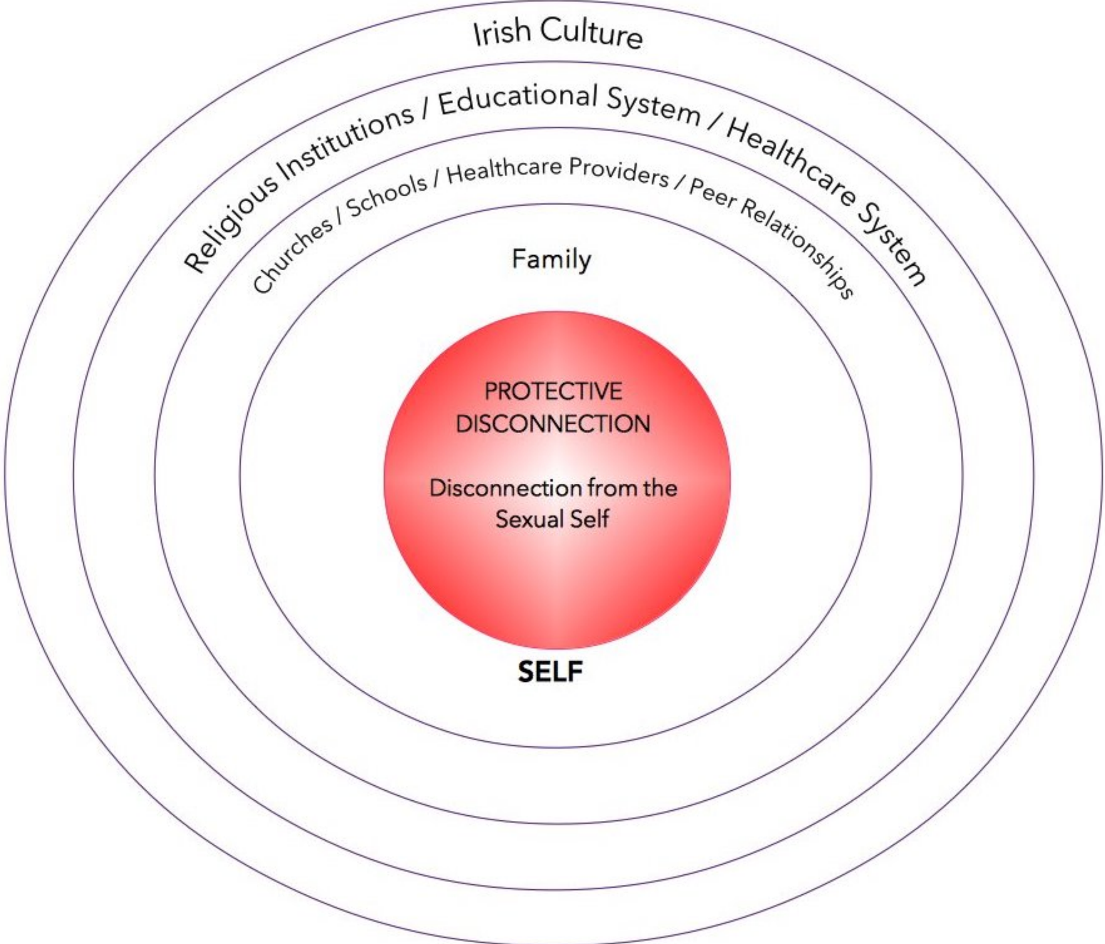
The historical legacy of Christian doctrine on the island of Ireland was seen to impact on the feelings of sexual shame and repression, especially for women participants, through in part the continued influence on sex education in schools. However, whether religion has an impact or not depended on the messages that were given in the household and how they were heard and internalised by the family members. The messages in the household for the women who are affected by vaginismus in this study were experienced as negative, shaming and threatening. There is a perceived preoccupation with family reputation and the perception of sex can appear confusing and threatening to daughters on whose perceived character the family reputation often rests. As a consequence, the messages the daughters are given around sex and pregnancy by parents can be internalised as frightening and threatening and have the effect of curbing their sexual desires and behaviour. Discussions with peer groups can add to the confusion and shame.

In this context, vaginismus can be understood as a psychosomatic condition. In order to protect herself from shame and physical and emotional pain, the woman may disconnect from

her physical body and the emotional and sexual feelings that are perceived as threatening in a culture that is unable to support them. The emotional and sexual self is repressed and the pain associated with sex and the body becomes vaginismus, a painful physical symptom in the genital area that predates the couple relationship.

Figure 1 illustrates the first phase of the development of the theory of vaginismus in the Irish context. This diagram represents the process of disconnection from the sexual self that the woman with vaginismus experiences in the context of familial, local, national and cultural influences that surround her.

Figure 1: Protective Disconnection in the Irish Context



Attempts at Connection

The second sub-core category, attempts at connection, represents two of the higher-level categories: experiencing intimate relationships as emotionally challenging and accessing accurate information is hit and miss. Attempts at connecting, in the context of these themes, represents the action of attempting to connect with emotional and sexual feelings and, in terms of process, represents the experiences of the couple as they enter into a sexual relationship and to try understand and overcome vaginismus.

Experiencing Intimate Relationships as Emotionally Challenging

The decision to enter into a sexually intimate relationship and the emotional challenge that characterises this process incorporates the experiences captured by three lower-level categories: endless attempts at failed or painful sexual intercourse, intimacy can affect and be affected by vaginismus, and partner puts her needs before his own.

Endless attempts at failed or painful sexual intercourse. Many of the therapists, a medical doctor and the couples interviewed spoke about a pattern of endless unsuccessful attempts at sex that was frequently very painful, physically and psychologically and this can get worse with each attempt. Macha said, "It got worse…we got to the point where we weren't really even doing very much…I think I just kind of clammed up a lot." A number of the women described the sensation of trying to have intercourse when the muscles were tight: "lots of pain" (Cliodhna), "It burned like a burn" (Eva), "quite uncomfortable" (Medb), "sharp darts of pain internally" (Liadain). According to Isolde and Tristian not only does the pain increase with each attempt, but also the frustration and the guilt and blame.

Vaginismus could cause physical pain and psychological trauma for the male partner too. Therapist Cian said that trying to have intercourse with a woman with tight muscles can physically hurt her partner's penis and so sex is also physically painful for him. According to therapist Aengus, vaginismus is, "traumatic for the women but it is….I won't say equally…

but it is traumatic for [their partners] as well.” He explained that, from the partner’s perspective, he may feel like he is sexually assaulting his partner when he is attempting to have intercourse with someone who is tense and anxious. One of his clients said, “I always feel like I am raping her.” Diarmaid said, “From a man’s point of view it was very difficult because when you feel like you are hurting somebody, obviously that is not very conducive to having sex.” Liadain’s partner Curither said, “It started to make me feel very conscious in bed because the last thing I wanted to do was to hurt Liadain.” Eva’s partner Lir said, “Eventually we would be intimate and I would want to go further…even a simple finger would be too difficult and uncomfortable…I have been guilty more or less from the start because I always felt I was causing all of this pain and discomfort [gets upset].” For Deirdre’s partner, Naoise who had had a previous sexual relationship, initially he couldn’t understand saying, “I was wondering like what did I do wrong?”

According to Therapist Eriu, if couples keep persisting with endless attempts at painful sex they, “essentially retraumatise themselves on a regular basis.” Of their unsuccessful attempts, couple Sadhbh and Fionn said “It would have turned us off trying because every time you try it is just disappointing and frustrating” (Sadhbh) and “You feel that you are making no progress” (Fionn). Couple Niamh and Oisin said, “We did try but we found it upsetting” (Niamh) and “We seem to have reached a plateau, yeah, I don’t know if it is solvable to be honest with you but sure that can we do except press ahead” (Oisin). Therapist Beibhinn said that, “the knock on effect is that it lessens the amount of actual closeness there is between them, as in being tactile with one another.” Some of the professionals said that some couples eventually stop trying and that that was generally a good thing. Therapists Banba and Nemain said, if the couples stop trying to have penetrative intercourse, there is a greater possibility that they will be sexual in other ways.

Intimacy can affect and be affected by vaginismus. The majority of the professionals interviewed mentioned that intimacy of all kinds can be affected by vaginismus but that this

depended very much on the couple dynamic. Some of the couples said that the vaginismus had not affected their ability to be affectionate and sexual in other ways and to connect intimately. Their experiences are discussed in the later section; sexual in other ways.
Some couples stated, however, that their ability to be tactile in any way was affected by the vaginismus because there was a fear that any affection could lead towards attempting intercourse. Therapist Eriu noted that women with vaginismus may not be very tactile in the first place, “for fear of it being misread that they are interested in sex.” Therapist Cian called vaginismus a “consequential dysfunction,” meaning that the woman disconnects from her sexual desire because attempts at sexual connection are going to be a failure and this increases her sense of guilt in the relationship.

> I think if there is any affection or whatever snuggling then I think, this is my feeling is that Tristian goes, “Oh! Maybe there's a chance!” So, or if snugging up in bed or whatever and it's like, “Oh!” And I just think because then inevitably if Tristian makes a move and I go, “No!” Then he gets pissed off and then either we do something while I'm sitting there gritting my teeth going, “This is fucking awful!” or else I don't do something and Tristian is pissed off and offended and then I kind of get the silent treatment (Isolde).

For some couples, making an intimate connection can be hindered by the couple lifestyle not making space for one another. Therapist Aengus said that it is important to look at the schedule of the couple and to make time to prioritise time for each other. Therapist Cian said, “People need to relax, go to bed early, lie around, spend some time together during the day, be loving in other ways…sex is part of the relationship.” Very often, the couples interviewed were trying to make an intimate connection under difficult circumstances. Couples Cliodhna and Ciabhan and Macha and Cruinniuc did not have any privacy at the beginning of their relationships because they both lived at home with their parents and constantly worried that they would be caught. Couples Niamh and Oisin and Deirdre and

Naoise were both preoccupied with a very busy work schedule and family commitments that interfered with the amount of time they could spend together. Medb said that she worried about the children coming in to their room but her partner Alill said that, “that’s an excuse…we have a lock on the door but we’ve never really locked it.”

Whether intimacy was affected or not quite often came down to the ability to communicate. Many of the therapists commented on the fact that many couples never speak even to each other about the difficulty. Some professionals said that often the only communication is during an argument and it becomes, “messy” (therapist Aengus) and “hurtful” (therapist Etain), “tears and recriminations” (therapist Bebhinn) and “avoidance” (therapist Cian). Some couples were not able to talk about the inability to have sexual intercourse at all initially, and for other couples there was an increase in arguments due to the frustration. Niamh said, “It was affecting our relationship, I think we were having more arguments than we, you know, needed to.” Sadhbh said, “We would have had a few arguments about it really…frustrated with each other even though it is obviously nobody’s fault…when you feel there is no hope of resolving it.” For couple Macha and Cruinniuc, arguments did not occur and instead they looked at the situation in a rational way. Macha said, “We didn’t [talk about it]…we didn’t put too much thought into it and I think we just thought that we were young maybe and we are not trying for kids…like we can do it when we are older…we have loads of time.”

Partner puts her needs before his own. Many of the professionals identified a pattern of a particular type of partner in the relationship, that was described as: “very patient, very kind” (therapist Banba) “easy going” (therapist Eriu), “very patient” (therapist Aengus), “very sensitive” (therapist Etain), “typical nice guy” and “very respectful” (therapist Bebhinn), “compliant” (therapist Nemain), “understanding, supportive” (therapist Danand) and “will tolerate that situation for a very long time” (therapist Aine). The partner can be hypervigilant in looking out for signs of pain in his partner (therapist Beibhinn) and can be very afraid of

causing pain and hurt (therapist Etain). They tend not to address the problem directly and take the lead from their partner (therapist Beibhinn). Therapist Aengus clarified, “I hate using the word patient, because that makes it sound like he was very good waiting for her. He was her partner, she should have done that anyway.” However, he added that often, when asked they will say, “Yes, I do feel frustrated.” Eva’s partner Lir said: “It is just tough being with the person that you love but you can’t be intimate with in that way.” Many of the partners in the interviews did put their own needs aside for their partners. Ciabhan stated, “It was more difficult for her than it would have been for me…you are open to doing what has to be done but the other person has to feel that way…and what they are going though is not going to be easy.” Deirdre’s partner Naoise suggested, “my role isn’t to feel sorry for myself,” and summed up his experience of frustration by saying:

> The condition is frustrating but I don’t think that should be the main consideration of the partner…it’s not going to help the situation if the partner isn’t patient or understanding, it is probably going to make it worse. So I think it is in the couple’s best interest, it is in the sufferer of the condition’s best interest but it is also in the partner’s best interests as well, you know? Like if, you know, it’s just going to create more anxiety and resentment later on if the partner isn’t of that mindset, you know?

The view of the partner being a typical ‘nice guy’, who put the needs of his partner before his own was not evidenced in all instances of the professional and couple interviews. Some therapists and medical doctors interviewed said that they have also had the experience sometimes where the partners are not understanding, but therapist Boann emphasised that this would not be typical. Family doctor Flidais said, that she had often encountered women who had been sent by their partners for a consultation saying, “He told me I should get myself fixed.” In terms of the couple interviews, Isolde said that women seek more than a sexual connection; they want to feel that there is also an emotional connection if the encounter is to feel loving. When her partner Tristian was asked about her suggestion that rough sex may

have contributed to her secondary vaginismus he did not seem to recall it saying, “Even now I can’t say what the roughness was, I would have to guess…probably more afterwards I suppose it was when you were saying it was hurting and it was rough.” When Alill was asked about his partner Medb disclosing that she had never found attempts at sex pleasurable he said, “I suppose a process that requires a lot of patience and possibly it mightn’t go right a lot of the time.” Eva’s partner Lir said that, “in particular with regard to dilators and vaginismus, I was very controlling I think.” Family Doctor Flidais said that experiences of this type indicated underlying relationship problems that are not evidenced in most cases of vaginismus. In the majority of the couple interviews, the partners were supportive and caring and understanding of their partners and often put the woman’s needs before their own. This understanding can provide a connection for a strong emotional connection between the partners that can be a facilitator for later sexual connection and will be discussed further in the section healing connection through relationships.

Accessing Accurate Information is Hit and Miss

When looking to outside sources for information, finding accurate information was found to be very challenging. The frustration inherent in the process is captured by the following four lower-level categories: medical professionals may not be adequately informed about psychosexual difficulties, referrals from doctors can add to the confusion, difficulty accessing services causes further distress, and awareness of vaginismus is needed for greater understanding.

Medical professionals may not be adequately informed about psychosexual difficulties. According to the professionals, the diagnosis of vaginismus is often made by the family doctor sometimes in the context of a smear being difficult or impossible. Often, in the experience of the therapists and medical doctors interviewed, family doctors do not discuss vaginismus with their clients to any great extent. Therapist Aine said, “[the experience in the

family doctor's office] would have been upsetting and difficult and embarrassing and they will have felt ashamed afterwards and confused …because usually the [family doctor] won't have discussed it with them." Therapist Eiru said that the experience is often dismissive. According to some of the therapists, family doctors will say, for example, "Well, I can't find anything wrong with you" (therapist Aengus) or suggest that the women should "just relax" and "have a glass of wine" (therapists Eriu, Aengus and Bebhinn). All of the women interviewed spoke about their frustrating interactions with family doctors. Cliodhna, Grainne and Niamh also said that they had indeed been told to go home and have a glass of wine and Grainne, in addition, had been told "Just go home and put in a tampon." Eva was told by her family doctor, "You should get sexy…just get flirty!" Therapist Brigid said, because of a family doctor's training, often they will see sexual issues including vaginismus purely in physical terms and may prescribe medication. Three of the women interviewed, Cliodhna, Niamh and Deirdre mentioned being prescribed anti-anxiety medication. Deirdre said, "If anything, [family doctors] created more anxiety for me because they didn't know what to do. And I am like, ok, if you don't know what to do, how am I meant to know?" Deirdre said, "I think the awareness is particularly bad and like I think it's bad when you go to a [family doctor] and they don't know." Sadhbh commented that when she visited her family doctor about her vaginismus, "I didn't think that there was even a solution being presented to me." Her partner said, "you go to your family doctor and they don't know, like you hit a stone wall." Cliodhna and Grainne said that the lack of compassion from family doctors was one of the most difficult experiences during attempts at help-seeking. Cliodhna's partner Ciabhan summed up their experience of family doctors by saying:

> It would be frustrating because you almost really know what you have to do but you need that guidance and that knowledge and someone with the motivation to get you through it. So if you are going to them and straight away they are referring you for medication or they are referring you to drink and things will open up and become

> better…you are thinking, well this is a professional and if this is who I'm talking to in this day and age, what hope is there?

Grainne added that she was particularly offended by the advice to go home and have a drink because, "I think it implies that, we wouldn't naturally choose to have sex but if we are a little bit tipsy, our body forgets itself." Deirdre added, "I can't really [get drunk]…I wouldn't really be in the moment."

Family doctors may sometimes seek to confirm a suspected case of vaginismus by attempting to do an internal examination. Being diagnosed by internal examination or attempts at internal examinations can confirm that the problem is a physical one to be solved medically, especially if no conversation takes place. The majority of the professionals but only a minority of the women interviewed thought that the internal examination was important to make an accurate diagnosis, to rule out physical conditions and to address fears. Medical Doctor Fand said that the internal examination can provide a way for doctors to open the conversation with their patients but, as evidenced in the section above, frequently that conversation does not take place and the internal examination often proves impossible and traumatic for the woman. Therapist Aine said that when a smear test is not possible and there is no conversation, it can reinforce their beliefs about their body being physically abnormal. In contrast, five therapists, one medical doctor and two of the women thought that there may be no need for an examination because the root cause of vaginismus is psychological in nature. Family doctor Flidais said, "You would not attempt to examine someone you knew had vaginismus because it is not a good thing to do, you are only going to make things worse…if the woman is telling you the problem is there, it's there." Therapist Boann said that, "I think you have to trust that [the women] know. Deirdre summed up her frustration with physical examinations by saying,

> I'd love if I could just say to a doctor do not fucking ask me about a smear test one more time…If you ask me about this one more time I am going to make a complaint…

> because you just wouldn't ask somebody that you know had fertility problems…when they were having their baby…So I don't really get why they feel the need to ask me about a smear test.

Many of the therapists and medical doctors interviewed thought that it would be very helpful for their clients if family doctors were to open the conversation with them. Family doctor Ernmas said appointment times are very pressured and that often sexual problems will be the last thing to be brought up in an appointment and at that stage, because appointment times are so short "the window of opportunity is gone." Grainne said, "And I was obviously there for another reason and there was definitely an air of, now you are here for this reason, you can't be taking up my time with something else!" Consultant obstetrician and gynaecologist Saoirse highlighted time as being a big issue for doctors saying, "We don't really have time to follow up." For Sadhbh it took a couple of months for the doctor to get back to her and the therapist to whom she was referred was unqualified to deal with vaginismus. Neither Cliodhna nor Grainne heard back from her doctor with regard to a referral. Cliodhna did not follow up, but on a subsequent visit Grainne was asked by her family doctor if she had made the appointment yet even though she had provided no information on referrals. Macha's family doctor mentioned cognitive behavioural therapy but gave no information and left it to her to go home and look it up. Couple Cliodhna and Ciabhan highlighted their difficulties with family doctors not following up and getting a different family doctor every time you make an appointment, which adversely affecting any continuity of care. Cliodhna and Deirdre both said that they felt they had to educate family doctors about what vaginismus is every time they see somebody new.

Therapist Aengus suggested that when people go in to a family doctor there should be routine questions asked such as "How is your mood? Any issues in terms of sex/sexual functioning…people go to their family doctor and they are nearly waiting for them to ask the question." Family doctor Flidais said family doctors can deny permission to speak by their

attitude, their body language because they don't know what to do and recommended that they should use a simple sentence like, "Are you having difficulties with sexuality…to give the patient permission to open up…and they always do." However, she qualified this by saying that although patients think that doctors should be the one to bring it up, family doctors think it should be the patient, but she added that, in her opinion, "If you are not talking to them about sexuality, sure you are not doing the job properly at all." Grainne's partner Diarmaid described family doctors as, "a gateway to whatever kind of counselling services or anything relevant… they should be able to give you more information. They should be forthcoming with information and not kind of dismissive." When asked to give advice to another couple going through the experience of vaginismus, couple Liadain and Curither said that they would recommend, "an open-minded [family doctor]."

Referrals from doctors can add to the confusion. Family doctors will frequently refer on to obstetric and gynaecological services rather than considering psychosexual counselling. According to therapists Etain and Bebhinn, who work in Northern Ireland and consultant obstetrician and gynaecologist Saoirse and physiotherapist Anu who work in the Republic of Ireland, the referrals from family doctors that they receive can be very vague and do not always name 'vaginismus.' They said that part of the difficulty is a lack of clear definition and training around what vaginismus is and the other can be embarrassment with dealing with psychosexual issues.

Being referred to medical services can confirm that the problem is a physical one to be solved medically, especially if no conversation takes place. According to therapist Aengus, medical professionals to whom the woman may be referred from the family doctor including consultants, nurses and physiotherapists typically will not have psychosexual training as part of their medical training and so will view vaginismus through the lens of a purely physical problem. In the professional interviews, therapists Aine, Banba and Fodla, spoke about doctors treating vaginismus with surgical dilation but, "it didn't deal with the problem. [The

women] still had anxiety and tensing," (therapist Banba). In the couple interviews, Deirdre, Cliodhna and Medb spoke about their experiences of being referred on to gynaecological services. Deirdre was referred to a gynaecologist when her family doctor was unable to do a smear test and when it wasn't possible said that there was nothing wrong with her and the pains she was experiencing were all in her head. Both Cliodhna and Medb were referred to a consultant obstetrician and gynaecologist to have an internal examination and stretching under anaesthetic when their family doctors were unable to do an internal examination. Cliodhna was sent for an operation because she was told by her gynaecologist that her hymen was too tight and after the operation was told, "You're perfect now, go have sex….went home about a week later was sobbing in my bed." When it was clear that this had not worked, her family doctor subsequently prescribed her a numbing agent for her vagina. Therapists Eriu and Bonann talked about women being referred to fertility clinics for invasive procedures without ever being asked whether the problem could be vaginismus.

Therapists Banba and Eriu expressed concerns about women being referred to physiotherapists who used dilators but did not address the psychological component and so the women may be, "further traumatised by the fact that someone tried to put something up," (therapist Eriu). Therapist Etain said that when dilators are recommended by obstetric and gynaecological departments there is very little progress because, "the treatment has not been properly explained or applied…some staff aren't comfortable…. especially when they are talking about dilators and there is a physical aspect to it." She added that, often the woman is blamed and labelled as "treatment resistant." Therapist Danu said that after five years of trying many unsuccessful medical treatments, a client of hers was told, "This is all in your head…you are crazy. You are making this up." Deirdre was offered Botox by her doctor. Two of the therapists, a medical doctor, the obstetrician and gynaecological consultant and the physiotherapist had reservations about the use of Botox for vaginismus both because of physical complications and the tendency to overlook the psychological aspect of vaginismus.

Therapist Beibhinn said, “the idea of Botox and stuff to override…I think [vaginismus] is there for a reason…and that needs to be respected.” Medical doctor Fand said that professionals need to recognise the importance of “paying tribute to the defences. If you try to beat a defence down, then it only gets stronger.”

Therapists Eriu, Brigid and Aengus highlighted that, in Ireland, there are no clear systems of referral, and so “there is a lot of family doctors that wouldn’t have a clue where to send somebody” (therapist Eriu). Therapist Brigid said that when family doctors refer on to psychosexual counsellors, it is usually initiated by the client rather than the doctor. Sadhbh, Cliodhna and Grainne asked their doctors for a referral when referrals were not offered to them. According to therapist Danu, by the time someone finds or is referred to a psychosexual counsellor she will have seen a lot of professionals, been given many diagnoses and will have tried all sorts of treatments. Cliodhna had been to many different professionals and had not resolved the difficulty. When asked if any of it was helpful, she said, “I don’t think so because I’m still where I am….I still feel like I was here the way I was five years ago or even seven years ago.” Her partner Ciabhan said, “There’s no care plan in place when you go to see someone.” When they are eventually referred to psychosexual counselling, it is often very confusing because their experiences have told them it is a physical problem. Therapist Banba said, “Sometimes you would have clients coming that don’t know why they are referred to me…they have just been told to go see somebody.” Some of the therapists, medical doctors and the physiotherapist interviewed thought that it would be helpful to have a multidisciplinary team approach. Niamh said that she thought that if she had been offered physiotherapy and psychotherapy combined it might have been helpful but, “it seemed hard to get…I haven’t come across people who kind of work together…and they would consult with each other then…I found [physiotherapy] so disappointing then because it wasn’t tied in with anything else.” Cliodhna said that attempts made to medically fix her did not work because,

"it's in our mind and it's in your body and that's just like a quick fix if it did work, but it doesn't work."

Difficulty accessing services causes further distress. Healthcare professionals from Northern Ireland and the Republic of Ireland were interviewed for this study and a very different picture of service provision emerged. Psychosexual clinics provided by the National Health Service (NHS), the health service provider in Northern Ireland, provide free and unlimited psychosexual counselling services. According to professionals interviewed who worked in Northern Ireland, medical doctor Fand, and therapists Etain and Bebhinn, family doctors who work north of the border will vary in their ability to discuss psychosexual matters but at least there are free psychosexual clinics to which they can refer their patients. However, therapists Etain and Beibhinn who work in Northern Ireland mentioned that family doctors may not be aware of services available and so will not refer their patients. Some of the professionals and couples spoke of the need to provide public psychosexual clinics in the Republic of Ireland as currently, there are no public psychosexual clinics apart from one or two attached to maternity hospitals and that the health service provider in the Republic of Ireland, the Health Service Executive (HSE), does not employ psychosexual counsellors. Therapists Banba and Fodla mentioned the waiting lists as being a barrier to accessing public services. Therapist Banba, who worked in a hospital in the South of Ireland had an eight month waiting list for her clinic and therapist Bebhinn who works in a psychosexual clinic in Northern Ireland said there was a year's waiting list but service level agreements give them the option to refer on to community psychosexual therapy support services. Two of the therapists, Cliodhna and Etain who work in the service, said that the services are constantly being cut and so often people end up paying for private services.

Some of the professionals interviewed mentioned the finances as being a barrier to accessing services in the Republic of Ireland. Therapist Aine said, "there is little available for women who can't access private therapy. And private therapy is limited because there are not

very many sex therapists in the country." Many of the couples highlighted the unfairness and the financial burden of having to pay privately for care. Macha said, "It was like €150 a session for like forty-five minutes….I was going every two weeks. I remember us being broke." Eva said, "We have no savings because of vaginismus." Fionn said, "We were lucky enough that we had options, or even the money or the access to get these people… which is unfair." Some professionals talked about the difficulties with having most of the services clustered around the capital. Niamh said that, in addition to paying for services, she also had to pay for travel and often accommodation in Dublin where many of the services are based. In addition, she said that quite often, the services she accessed turned out to be unhelpful and a waste of time, money and effort. She said, "the only way I can find out is to spend the money and the time and to go and have several sessions before I can find out are they any good or not and I just don't always have the time and money to do it," and added, "You need to go and talk about all this intimate stuff that a lot of people don't ever need to talk about…it is very difficult to go to new people all of the time."

Some of the therapists and medical doctors interviewed commented on the lack of psychosexual therapists in Ireland to cover the demand. Deirdre spoke about the limited opening hours of psychotherapy services which is often 9:00-5:00 on a weekday, and needing to ask for time off work to attend sessions. One of the main reasons that she was paying privately and did not access the Employee Assistance Programme (EAP) provided by her employer was that she was concerned about who would have access to the information about her sessions and she was also reluctant to ask for time off in case she was asked why. Couples Sadhbh and Fionn and Macha and Cruinniuc also highlighted their concerns about privacy and being seen accessing counselling services in their locality.

The interviews revealed that sometimes, a family doctor will not provide any information about referrals and so it is left up to the woman to search for therapist online. Many of the therapists interviewed had concerns about counsellors offering treatment for

vaginismus online who were not qualified to do so. Therapist Danand said, "The work I do on sex therapy is a combination of all my own experience pulled from different places…I'm not claiming to be a sex therapist but I think I successfully treat it." She said that there were no psychosexual therapists in the region of Ireland where she offered her services and said, "I'm experienced enough that if I can help someone, why would they be driving up and down to Dublin? That is my attitude." Many of the couples interviewed had tried to find help by themselves with varying degrees of success. Sadhbh recountered her experience of going to a therapist that she considered not to be very knowledgeable about vaginismus, "His advice was to go home and attempt to insert my fingers myself over time…And I kind of thought like, if I could stick my finger in there myself, you know?...that is a really hard thing to do when you have severe vaginismus." There was no follow up offered and she was told the problem would just resolve itself over time. Both Niamh and Isolde had experiences of counsellors that put all of the blame on them saying that they were not fulfilling their husband's needs. Deirdre had been to a number of counsellors and when comparing a 'general' therapist to therapists with psychosexual training said, "The general therapist didn't really seem to have a good kind of foundation knowledge." Therapist Cian highlighted the need for regulation of the qualifications for sex and couple therapy, yearly continuing professional development, a licence to practice, and supervision for anyone who wants to treat couples. Some of the therapists interviewed including Banba, Eriu, Fodla and Aengus had to go to the UK for training and thought that psychosexual counselling training should be offered in Ireland.

Many therapists interviewed said that the media can be an excellent resource and can give information and normalise vaginismus for the client, encourage them to go for help, and provide information about support services. Some couples had had positive experiences looking up information on vaginismus online, including websites such as vaginismus.com or the website for the National Health Service, newspaper articles and chat rooms because it normalised the experience. Macha said when she found information on vaginismus online, "I

was a bit relieved and being like, ah ok right, I'm not like, broken or whatever, I'm not on my own." Some experiences online were less than pleasant. Therapists Aengus and Cian said were concerned about the general nature of the information available online that might not apply to that particular woman or couple but adds to the confusion. Therapists Aine and Fodla highlighted that a lot of information tends to focus on the physical aspect of the condition which can reinforce the idea of the problem being purely physical in nature. Grainne said that a lot of the websites tended to focus on, "a possible medical condition…focusing on the scary stuff." Therapist Fodla raised concerns about misinformation on the internet. Grainne said that she made a link between having vaginismus and sexual abuse after going online and said, "Actually that I found quite difficult at the time reading about it all….a lot of it was victims of rape or things like that."

Awareness of vaginismus is needed for greater understanding. Some of the professionals and couples thought it would be helpful if family doctors had some basic training in psychosexual matters or could provide referral information. Therapist Eriu said that "[family doctors] are a loss about what do about it," so it is vital that there is awareness and education and advertising about vaginismus and services available. Some therapists and couples agreed that an ideal place to provide an information sheet would be the primary healthcare setting. Sadhbh said that if information leaflets were available, it would reduce the sense of the condition being taboo or embarrassing

All of the women and all but one of the partners interviewed had never heard of vaginismus until it was an issue for them and Macha and Liadain stated that you can't ask for help when you don't know what you are dealing with, and don't even have the language to ask. Eight of the couples also highlighted that awareness in the general public, such as articles in the media, would help to reduce the confusion, stigma, isolation and guilt that women and couples feel when they experience vaginismus. Some of the couples said they would like people to understand how common the problem is. Therapist Danand said, "Because of the

secrecy around it, is very difficult to know how common it is." Two of the couples highlighted their perception that couples with fertility issues are treated with great sympathy and understanding because there is such an awareness of these issues. Niamh said, "People can't have children, it's very similar, the emotions are kind of similar but at least to a certain extent you can talk to people about it and people understand…people would be aware of the issue." Medb said if there was more awareness of vaginismus, "It might take away the guilt for people and the pressure and everything is supposed to be rosy in the garden and that it's easy."

Three of the couples said that they believed that there was a general perception that if you have vaginismus, both from medical professionals and the general public, that you must have been sexually abused. Cliodhna said that the general perception was, "Obviously like women that have been raped would have vaginismus," and her partner Ciabhan said that that added to the stigma when going for help. Sadhbh said that when a smear test was not possible the practice nurse assumed that she was going to say something about being sexually abused and cut her off straight away. She recounts: "I would say that she didn't want me to suddenly say, Oh, I was sexually abused as a child or I was raped or something and this is a big mess." Another friend of hers that she confided in about her vaginismus said, "Sure, that's only people who were sexually abused." Many of the professional therapists, a medical doctor and the physiotherapist interviewed, noted that sexual abuse can be a factor in a minority of cases but was not usually a factor. According to Therapists Aine, Brigid and Bebhinn, the women are often terrified of the vaginismus being found out in case people automatically assume they have been sexually abused. Therapist Eriu said that the assumption that vaginismus is linked to sexual abuse leads to further pain and confusion with clients beginning therapy sessions by saying, "I can't understand why I have this, because I wasn't sexually abused. I know that everybody would assume that I was, but I wasn't." Therapist Fodla said that if women have not been sexually abused but have vaginismus they will start worrying about whether

something had happened that they have repressed." Grainne said that after reading online about the link between vaginismus and sexual abuse, "You feel like either you're completely blocking something out from the past…or you are a very abnormal person who is behaving like a rape victim...even though you are not."

Attempts at Connection Section Summary

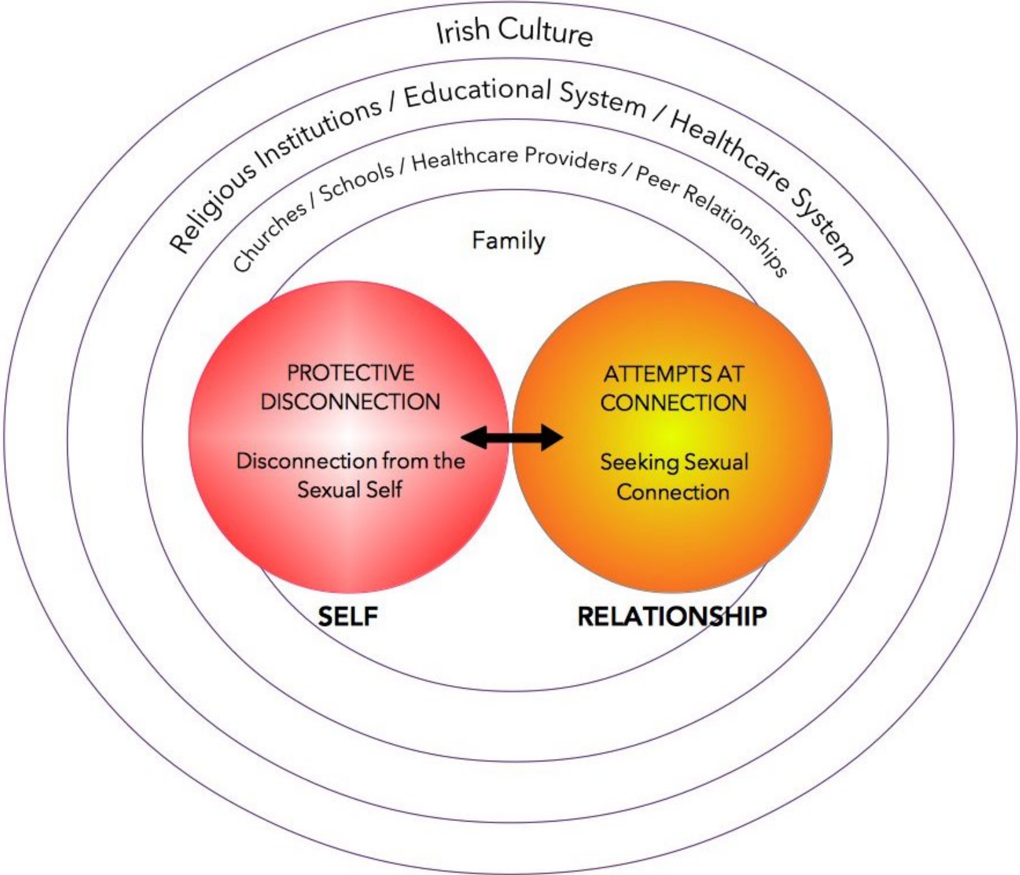
Not every woman will make the decision to enter into a couple relationship because it is quite emotionally challenging for someone who perceives a sexual connection as potentially threatening. The couple relationship is an opportunity to confront fears about connecting sexually with a partner but these fears can be compounded when experiences in the relationship or experiences of seeking answers are frustrating and upsetting. According to the data in this study, the couples will often try to find their own way through the difficulty by having endless attempts at painful sexual intercourse that can be traumatic and can affect attempts at any intimate connection. For individuals who find it difficult to communicate about sexual matters, it can be difficult to communicate their needs even to the person with whom they are having a sexual relationship. Sometimes they find it difficult to communicate their own emotional needs to one another. According to the professional and couple interviews, the majority of partners were understanding and provided emotional support to their partners even when that meant putting their own needs aside. This understanding facilitated an important emotional connection that can be used as a foundation for later attempts at sexual connection.

Many of the couples attempted to access information about vaginismus but finding accurate information was hit and miss. Medical professionals may not be adequately informed about psychosexual difficulties and referrals to medically based interventions can add to the confusion and reinforce the idea of vaginismus being a physical problem and of the body being broken. Difficulty accessing services and misinformation online can cause further

distress. This distress could be avoided by understanding vaginismus as a common problem and the provision of accurate information by primary healthcare providers to whom the women often go to initially. The need for family doctors need to give the women permission to speak about sexual matters and to open the conversation with them to reduce the sense of shame and taboo around sexual matters was identified.

Figure 2 illustrates the second phase of the development of the theory of vaginismus in the Irish context. This diagram represents the process, for the woman with vaginismus, attempting to move from protective disconnection to attempts at connection in an intimate relationship. This part of the diagram also represents the process for the couple of attempting to connect sexually in the context of familial, local, national and cultural influences that surround them.

Figure 2: Protective Disconnection & Attempts at Connection in the Irish Context



Healing Connection Through Relationships

The third sub-core category, healing connection through relationships, represents two of the higher-level categories: experiencing the relationship as a way of connecting with disconnected aspects of the self and experiencing therapy as a way for both partners to connect in the relationship. The power of relationships for both interpersonal and intrapersonal healing, is captured in these themes. This process describes the elements that combine to contribute to the resolution of vaginismus.

Experiencing the Relationship as a Way of Connecting with Disconnected Aspects of the self

For some couples, their relationship, although being emotionally challenging, was also an opportunity to connect both with each other and with disconnected parts of the self and the body. The experiences of couples who find ways in their relationship to heal are captured in the following three lower-level categories: relationships are sound despite the vaginismus, sexual in other ways, and a decision is made to resolve the problem.

Relationships are sound despite the vaginismus. The majority of the therapists and the obstetrician/gynaecological consultant interviewed said that couples who experience vaginismus generally have a sound, supportive relationship and vaginismus tends to be the only problem. Therapist Aine said, "I wouldn't say it is a relationship problem, I would say it is a couples' problem…if you say to a couple who have a sound relationship, it is quite confusing for them if you say, this is a relationship problem." For most couples, vaginismus was not found to be indicative of an underlying relationship problem. Therapist Aengus said, "It is the connection between them and it is the love that holds them together…the trust the intimacy and all of that…their fulfilment is coming from other parts of the relationship, so it is not all based around [sex]."

Rather than being detrimental to the relationship, many couples thought that their experience of vaginismus had actually strengthened their relationship. Sadhbh and Fionn had resolved their vaginismus at the time of the interview and Fionn said, “We were strong enough to come through this together.” Macha, who had also resolved her vaginismus at the time of the interview said of her partner:

> I do know that he loves me for me. And like I know we are married now and all of that kind of stuff so he would, but I knew back then it was very reassuring that he stayed with me, do you know what I mean? That like we do have this issue but he does love spending time with me and he loves all the other aspects of it…I never worried that he would go, which was lovely.

Liadain, who had also resolved her vaginismus said that one of the things that helped her to overcome it was, “a very loving and patient partner.” In some cases where the vaginismus had not been resolved, couples still chose to concentrate on the positive and fulfilling aspects of their relationship. Ciabhan said, “We are still together and we’re still remaining positive.” Cliodhna said of Ciabhan, “He holds me up.” Niamh said, “We do care about each other and we’re strong together and we’re really committed to each other.” Deirdre said, “I think it kind of binds us together a bit because we are getting through it together.” When she put herself down in the interview saying that she didn’t feel like a proper wife, her partner Naoise said,

> If it doesn’t happen it doesn’t happen, we’ll just deal with it and move on…I hate the sound of Deirdre saying that she doesn’t feel like a normal wife or anything like that because it couldn’t be further from the truth, you know? Like this is an aspect of a relationship but it is not the most important one or even close to it.

However, in the case of three of the couples who had not resolved their vaginismus, the relationship was not as sound. Eva’s partner Lir said of the vaginismus, “It has come so close to destroying our relationship so many times.” In this particular case, the partner put the

blame on himself for being controlling and impatient during the therapeutic process. At the time of the interview, the couple were in couples therapy to help them to communicate in a more healthy way. Medb's partner Alill stated that the vaginismus wasn't really the issue. Speaking about the beginning of the relationship he said, "[Sex] wouldn't have been the defining factor in the relationship…it was to have a relationship with her, so it was fine." But after decades of failing to resolve the issue and the possibility of breaking up he said, "There'd be other factors as well I'd imagine…such as a row over something else…I don't think it would be the sole reason, but it doesn't help it, the fact that you are not being intimate." For Isolde and Tristian who had very little intimacy even prior to the vaginismus and said that a mismatch in their sexual drives was the fundamental problem. Although the interviews with professionals in this study suggested that vaginismus is not generally indicative of a deeper relationship problem, existing problems can be exacerbated by the vaginismus. If vaginismus is the only concern then generally couples do not break up and decide to work at becoming more intimate by being sexual in other ways and hopefully finding a resolution to the vaginismus.

Sexual in other ways. "Sexual in other ways" was an NVivo code coined by Therapist Etain who explained that the ability to be intimate and sexual in other ways facilitates the resolution of the problem:

> They are sexual in other ways. They are not sexually frustrated as such because they are able to express themselves sexually in other ways…they do find their own way…it is quite affirming really because, you know, when you get to deal with couples like that, everything else is solid that really you are not trying to deal with six or seven other issues you know? You are really able to focus on the vaginismus.

Many of the therapists, the medical doctor and the obstetrician/gynaecological consultant said that in their experience, despite the vaginismus, couples are often still very

intimate and sexual with each other in other ways. Medical doctor Fand said, "A lot of women with vaginismus are sexually active, they are orgasmic, they have no problem with arousal…it is not about sex, it is about vaginal penetration." All but two of the couples were able to be intimate with each other and sexual in other ways despite the vaginismus and this can reduce the frustration and loneliness. Cruinniuc said, "I wasn't worried that Macha didn't fancy me or anything because we would have done other stuff and kissed and hugged and stuff…I just thought that….she didn't fancy having sex." Liadain explained that it is important for the relationship to, "Look after your partner as well because it is really hard on them…I could definitely see some of them…assuming that it is because they are not attracted anymore, they don't want it anymore and kind of going down that more destructive route." Eva's partner Lir said, "I haven't experienced loneliness thankfully because I think we have been good in able to kind of express intimacy in other ways and just being connected." Many of the couples would say that they have a very good sex life in the absence of penetrative sex. Cliodhna said, "I just want people to realise like we're still a couple and we still do normal things, just 'cos we can't do intercourse, we still have a sexual relationship." Naoise said, "outside of sex there is no physical barriers," and his partner Deirdre said, "maybe we overly sometimes because we are making up for it."

A decision is made to resolve the problem. By choosing to be in an intimate relationship, in some ways the woman has made the first step towards facing and challenging the vaginismus. Some women find it impossible to make that step. Therapist Boann explains that, "a lot of people…with attachment issues…can't even get to the stage of being intimate," but women with vaginismus who enter relationships have "pushed through a certain barrier and gotten themselves into [sexually intimate] situations." Being in a relationship and having sexual difficulties can provide a catalyst for women to begin to examine the effect of their upbringing and the negative messages they have internalised on their sexuality. Therapist Danu explains:

> Core beliefs and automatic thoughts and how you soak up a value when you are a kid and it doesn't get questioned until we are being sexual ourselves and even then it doesn't get questioned unless, of course there is an ongoing problem.

Therapist Boann said that on entering the relationship it moves from being a personal challenge to a couple's challenge. At some point in the relationship, a decision is made to resolve the vaginismus for various reasons. Many of the professionals and some couples cited wanting to start a family as a very effective motivator for change. Some of the professionals said that they had found that the main motivation was to have sexual intimacy and that having children was secondary to that. They cautioned that if the goal was solely for procreation rather than intimacy then the woman may be able to tolerate sexual intercourse in order to conceive but there is very little sexual intercourse otherwise. This was the experience for two of the couples who had only managed to have sexual intercourse when they wanted to get pregnant but said that other than that they had little sexual intimacy. Medb said, "I can't relax. So that is why sometimes alcohol would take a bit of the edge off that where I could try to kind of push though." This couple had managed to have five pregnancies with two miscarriages and three successful full term births and yet could not have sex for pleasure. For many of the couples experiencing primary vaginismus whether they might wish to start a family or not, the main motivator for wanting to resolve the vaginismus was not to have children but to increase their sexual intimacy. Deirdre said that her partner, who had had a previous sexual relationship, told her about how sex was more about intimacy and bringing couples closer and she said,

> Naoise used to say to me, 'I know from my own experience how it can make couples closer and like how it is really more about intimacy.'….I trusted him so I'm like, ok, clearly I'm missing out on something here.

Most of the couples thought that the vaginismus would simply resolve itself over time and in some cases attempts to resolve the problem within the relationship were successful.

Two of the couples who were experiencing secondary vaginismus did manage to resolve the problem without going for professional help. Grainne's partner Diarmaid said that they worked together over the course of a year using a patient trial-and-error process of touching and massage and relaxation, "trying to hoodwink your body somehow…swerving around that sort of mental whatever it was." Liadain's partner Curither said that they used, "Extended foreplay…taking it much slower." Therapist Banba explains that couples experiencing a case of secondary vaginismus, "would be at a very different stage, that they have been sexually active…they know what it is about and they are still being sexual." Physiotherapist Anu said that women with primary vaginismus are harder to treat because the women, "have never known to associate the pelvic floor with pleasure they have only learned to associate with pain." Deirdre said, "When you haven't had sex with somebody, I think it is very hard to understand how it can be…another dimension or aspect to the relationship." Eva's partner Lir said that reading accounts online of people with secondary vaginismus who had resolved the difficulty made him feel more hopeless. He explained, "I would be jealous, yeah, I get nearly angry when they talk…about not having sex because of that like I would be saying I have nothing to attach it to, no memory."

Seven of the couples in the study were experiencing primary vaginismus. Of those, only two had resolved the problem at the time of the interview because of very positive experiences with psychosexual therapy. For the remaining five couples, they had had mixed experiences with help seeking and had not manged to resolve the vaginismus at the time of interview. Positive help seeking experiences are discussed in the following section.

Experiencing Therapy as a Way for Both Partners to Connect in the Relationship

For some couples, the sexual relationship is so emotionally challenging that help and support may be needed from knowledgeable and supportive professionals. Within the therapeutic relationship, the partners can find ways to connect in their relationship. These

experiences are captured in the following two lower-level categories: the therapeutic process can help with understanding and overcoming vaginismus and vaginismus can be more effectively resolved together as a couple.

The therapeutic process can help with understanding and overcoming vaginismus. The therapeutic relationship can facilitate greater understanding of vaginismus by providing psychosexual education, understanding the facilitating factors that contribute to and maintain the difficulty, understanding the problem as a physical manifestation of a psychological problem and providing a structured and supportive programme for its resolution. Sadhbh, who had successfully resolved her vaginismus in therapy said, “we wouldn’t have been able to do it on our own…it seems like it was an awful lot in wasted time…where we needn’t have had all those years of stress.” Liadain said, “You can deal with almost anything if you can name it…it is that kind of whirlwind before of not knowing.”

Just as going to see a medical professional can reinforce the idea of the problem being primarily physical, going to see a therapist can help women and couples to begin to consider that the problem may have a psychological component. Some professionals said that sometimes the women themselves would prefer that the reason was physical because they see it as easier and quicker to fix than one that is psychological. Niamh said, “In the early days I thought, oh I don’t really want to go the psychological approach because they will be messing with my head and bringing in all these other issues.” However, for many of the couples understanding vaginismus as a physical manifestation of something psychological was a turning point in their ability to deal with it. Eva said: “I think if you get a hold on [the psychological aspect] a bit more, the physical comes with it then.”

> The most helpful thing a sex therapist said to me was, remember that this is your body doing something to protect you so you have a good healthy body, you know, now it’s going a bit overboard but there is nothing wrong, it is a normal reaction and it is healthy

> and it is trying to protect you but you need to understand why you feel the need to protect yourself (Deirdre).

Apart from believing that the problem is purely physical, couples often do not realise how prevalent vaginismus is. The majority of the therapists, the physiotherapist and the obstetrician/gynaecological consultant commented on how common vaginismus is in Ireland. Therapist Boann said it was important to normalise vaginismus because, “It is all that is around it that is difficult, the shame, the sense of failure, the self-worth, all…compounds the issue.” As mentioned in a previous section, the woman often believes that the condition is unique to her because she has never heard it. Some couples had found out about vaginismus by looking it up on the internet, and others had been told by their therapist or medical professional. Medb said, “I was relieved that there was such a condition, that it wasn’t just me.”

The majority of therapists, doctors and the physiotherapist incorporated psychoeducation to fill in the gaps left by inadequate sex education and lack of knowledge about the body and to provide a counterpoint to the inaccurate or frightening messages that may still be having an impact. This may include teaching basic anatomy and practical advice on sex.

> One of the best ways of getting people on board is (1) to listen exactly what they are saying and what their fears are and (2) to give a really good psychoeducation…they are generally able to see, ‘Well actually, my body, even if I think is broken, is mainly ok’ (therapist Etain).

Apart from understanding the psychological aspect of the difficulty, it can also be helpful to know that there is nothing physically wrong. Deirdre said that going to a physiotherapist, “helped to break that mind barrier to say that like right there is definitely nothing physically wrong with me.” The majority of therapists, the medical doctor and the physiotherapist interviewed incorporated the use of trainers or dilators into their therapy.

Therapist Beibhinn explains, “I think there is something for the woman… having the control of putting something inside and the experience of having something going inside and it not being painful.” Eva said, “Having control over something like the muscles….gives me a sense of ownership which is really nice.” However, it is very important that the woman gets the proper support from professionals who suggest using the dilators. Therapist Etain said that sometimes medical professionals will tell women to get them and use them but the process has not been properly explained to them and they are unable to progress and feel like failures.

Over half of the women said that the use of dilators were suggested by their health care providers and managed to insert them but still were unable to progress intercourse. Cliodhna explained, “It’s totally different. You have no control [with intercourse] and I did try and no, it didn’t succeed.” Deirdre said that she couldn’t attempt to use the dilators because they look, “Horrendous, like a penis looks way friendlier than that…a plastic object inside of you, it just doesn’t make sense to me.” Niamh said, “If it is just the practical approach…that can be a bit cold. I think you do need the two sides.” Some therapists said that dilators are favoured by women who don’t like to touch themselves and, as therapist Nemain put it, are, “that way disconnected.” Three of the women were more comfortable using dilators than fingers because it afforded some distance. For two of the woman they managed to do the dilator therapy and progress to intercourse without any support through sheer force of will. Liadain said, “Another thing I guess about myself…it is just like ferociously determined to get it, to make it work…a bit of pain was nothing compared to the physical pain of [sex].” Macha took the advice of a blog and, “I just kind of shoved it in…then I was able to move on them and progress faster.”

Family doctor Flidais said she would only use dilators as part of a behavioural change programme. Physiotherapist Anu said that often the instructions given by medical professionals or online are completely inaccurate because inserting something is not stretching the muscle and this can be explained and facilitated in physiotherapy sessions.

Sadhbh and Macha were aided through the process of using the dilators as part of a sensate focus therapy by their therapist and their attempts were much more successful and eventually led to penetrative intercourse. For Eva, her experiences of dilators were traumatic because her partner suggested that she order them online and closely supervised her progress. She said of her experience, “The first one was always very painful and we’d get onto the second one and I would lose all faith in everything and I would stop for ages.” They subsequently found therapists who could work with them but the focus was on their relationship and issues around boundaries and control. They had not resolved the vaginismus at the time of interview.

Many of the couples had been through a behavioural change programme with a therapist with varying degrees of success. Two of the couples found it very successful and had completed the programme, including penetrative sex. Both couples credited the support of the therapist in helping them to complete the programme. Half of the couples said that the programme had increased their intimacy but had not led to intercourse. However, at the time of the interview, three of the couples had given up on the therapy and two were still progressing with it. Both were hopeful of resolving the problem and credited their therapists for their ongoing support. Deirdre said, “There is a lot of hope.” Eva said, “There has been the most progression….like mental progression taking ownership of me and ownership of my body.”

A number of factors were identified by the participants as common stumbling blocks which can stall the therapeutic process including the need to fix what is perceived to be the broken sexual self quickly, the tendency for the couple to ruminate and spectate, and to be overwhelmed by feelings of anxiety and defeat. During this time, the therapist can help through providing encouragement and empowerment.

Many of the therapists and the physiotherapist spoke about the pressure their clients put themselves under to fix themselves and wanting to resolve the problem quickly. Some therapists mentioned the pressures of fertility, which led in some cases to couples opting out

in order to progress quickly through in vitro fertilisation rather than taking the time to resolve the problem. Some therapists mentioned that wanting to progress quickly could be linked to the anxiety and control issues that were mentioned earlier in the chapter. Some therapists spoke about the pressure that the women put themselves under and how critical they are of any perceived set back or of not moving quickly enough or achieving enough. Therapist Eriu said that sometimes women and couples drop out because, "They just feel too overwhelmed. I think the old messages of there is something wrong with you, you can't do this, start coming back into focus." Therapist Beibhinn explained that if a woman does not feel good enough because of her upbringing, it leads to behaviours, "At an unconscious level…make reparations, fix that, you know, cover up for that and fix yourself ultimately." Two of the couples who hadn't resolved the issue at the time of the interview, had dropped out of therapy because it was taking too much time. Cliodhna said, "I just felt like I wasn't quick enough and as the weeks went on and on…I kind of gave up then." Niamh said, "There is this issue that I haven't resolved and it is something that I should be able to fix and I can't and I should be able to do it." Some therapists and a medical doctor said that sometimes it is the case that the couples drop out because the programme is successful and they are progressing towards having intercourse and get scared. Family doctor Flidais said, "change is just too painful."

> Because if someone has been holding on to this and this way of life and have told themselves that they can't have sex or don't or are not able to, you know, they will come up against a wall of, 'Well how do I live my life post that?' That they are now a sexual being (therapist Brigid).

When the couples had setbacks, it is important that they receive support and encouragement from their therapist. Therapist Eriu said that this can happen at the start of therapy and they need to have hope and to realise how successful the treatment is to motivate them, it can happen during therapy when they have a setback and coping skills need to be taught to empower and motivate the couple. Fionn said, "I think maybe the next time we tried

it we might have failed. But we said look we can still fall back on the previous time that we were successful…it was mainly the encouragement as well [from the therapist].” Many therapists said that an important part of motivation and encouragement is to remind the couple to celebrate every little success along the way until the problem is resolved. Therapist Danu said, “I notice every little progress that they make and I name it for them…..this all helps them to be able to trust that where I am taking them is going to be safe.” Some therapists also spoke about maintenance therapy to provide support when everything had been resolved. Therapist Etain explained: “It is really about building up confidence…broadening their repertoire…making sure that they’re ok…things are moving forward ok.” Macha stated that the most important thing she had received from her therapist was hope and she returned to her when she needed additional help. Deirdre suggested, “it takes time and everything but there is a lot of hope and it certainly can be resolved once…you get the right person and the fit between the person and therapist is so important.” Eva, who had been to many professionals described her current therapists, with whom she was making progress as “nurturing,” and said “you have to have that connection with them.”

For some women there was a lack of connection with the therapist that led to them dropping out. Therapist Banba spoke of the importance of the therapist-client fit by saying, “They would have dropped out because they didn’t connect with the therapist and I would imagine it is vice versa.” Cliodhna said that her therapist made her feel judged for not progressing enough and that she was just bothering him, but she did acknowledge that her anxiety may have affected her perception. Isolde and Tristian felt that their therapist was old fashioned and put the blame solely on the Isolde for their sexual difficulties. Eva could not identify with her former therapist’s approach saying, “I don’t think we connected very well.” Her partner Lir said that their current therapists were better because, “It is way more structured and kind of you understand the reasons for it.” Liadain also felt she didn’t “click” with her former therapist and did not return. Three of the couples said that they stopped going

to therapy because their therapists was not welcoming towards the partner attending the sessions. Medical doctor Fand explained that some approaches, such as psychoanalytic psychotherapy, "don't study the couple…we look at the patient as it being her problem rather than it being a relationship problem." Other professionals would give women the choice of whether to include their partner but many said at the start that the woman, herself, could be reluctant to include him. One of the reasons can be that the woman sees this problem as her problem to sort out and doesn't feel that her partner would engage. They may also worry about how their partner's perception of them might change if, for example, they were to be examined or to use dilators in their presence. Physiotherapist Anu also explains, "they genuinely feel it desexualises them in front of their partner." Liadain said that she did not want her partner around when she was doing her dilator therapy. She explained, "I believe...you could seriously damage your relationship by crossing certain lines." However, without the partner's support it can be hard for the woman to continue if she has a setback (therapist Eriu) and the partner can feel alienated from the process and want to be involved and to help (therapists Banba and Aengus). Sometimes it is not possible to see both partners together for logistical reasons, e.g. work schedules (therapists Aine and Nemain).

Vaginismus can be more effectively resolved together as a couple. As well as the therapeutic relationship being supportive, it can help couples to understand vaginismus as a couple problem rather than the woman's problem alone and to encourage both partners to work together as a team to resolve the issue. The majority of the partners interviewed wanted to be part of the therapeutic process. Some of the therapists said that one of the most important aspects of including the partner was to take any sense of blame away and to help the partner to understand that the problem was a couple problem that could be resolved together. Therapist Brigid said, "Even though [vaginismus] is manifesting in one person's body …it is a problem for both of them if they can't have sex." Fionn, who was reluctant at the start but eventually did attend therapy explained, "I was thinking that maybe it wasn't my

issue but then over time I probably thought that that was a bit selfish. I mean there are two of us in the relationship so if I could help I should probably help." He added, "[attending therapy] would be fairly beneficially because at the end of the day like the two of us would have to work together anyway to get to the resolution so the sooner the better." Partners Ciabhan, Oisin and Alill who attended therapy sessions more or less from the start said that it helped them to understand what their partners were going through and how they could help. Deirdre asked her partner to come to her physiotherapy appointments and said that not only did it help him to understand but also motivated him to find out more about vaginismus so that he can be more understanding and, "just being patient and just knowing that look everything is being done to get it resolved." Therapist Boann said that vaginismus is most successfully treated when it begins with a "connected relationship."

Many therapists and the physiotherapist recommend that a woman does some self-focus work that involves looking at and touching her own body and this helps her to connect with a body that she has felt disconnected from and associates with pain and shame. As discussed in a previous section, often the women would not have taken the time to explore their bodies. Therapist Nemain said that this extended to not even to take time for herself even to have a bath or massage or anything that involved spending time with the body. Physiotherapist Anu said that self-touch was very important, "Because it is important for you to love yourself first before you go and love anyone else." Family Doctor Flidais said, "What you are trying to do with the exercise is to come back into your body and be aware of what your body sensations are." Eva described the personal benefit of the self-focus exercises, "I am actually feeling these days like a sexual being which has been the first time in my whole life." She added, "For me, setting boundaries is a big thing…I do think it is helping with the negative thoughts." Therapist Nemain said that women who can progress to touching their bodies want to connect with their bodies but others, "are not able to just start owning every part of themselves including this inch and a half muscle that is at the beginning of their

vagina." Therapist Etain said that it is possible that the women will never be able to touch their genital area and that needs to be respected. She explained:

> At one level, I would love the woman to [touch their body] but on another level I think, well no, I have to be respectful of what she wants to do with her body. That's part of ownership. So if she doesn't want to do that, if you wants to use a dilator or if she wants to use something else, fine. Because if it works for her, that is the important thing because that is partly ownership of her body to say, this is something that is not going to touch it, her hand, you know?

Some of the therapists indicated that even if the partner is not directly involved, he can provide encouragement and do practical things like making sure she has a private uninterrupted space to do her individual work and to be there to support afterwards. Even though the partner is not directly involved during the self-focus, he can provide emotional support for his partner during this time. Therapist Eriu said, "That is why I love the partner to be involved if at all possible because I think sometimes that's the pivotal role the partner plays is encouraging and to let the woman know that he really wants to see this happen and move forward." Deirdre said that her partner Naoise was always available to talk and although sometimes she could not discuss how the sessions went until later because she was trying to process it, at other times they could discuss it. She explained, "If the session was good and I was able to gather my thoughts, I'd tell him how it went straight away and this is kind of our plan for the next two weeks." Therapist Aengus said that there is also a lot a partner can do in practical terms to help the woman progress with her self-focus work. He explained, "If she is going to be doing some practice…she needs peace and quiet…there is a lot of things in terms of just practically doing [self-focus], making sure that you are not going to be disturbed." Physiotherapist Anu said some men are willing to help in a practical way and can be involved in self-focus or dilator therapy. Deirdre and Naoise found that attending their physiotherapist together was very beneficial. Naoise said, "In terms of the practical

things in terms of treatment, I think that leads to a lot more of awareness of…what Deirdre was dealing with…When we were given the homework to do…I could see Deirdre's reactions, and that makes it all the more obvious that…this is a real thing."

Even if the partner is not involved at the beginning, most therapists will suggest that he is involved in order to progress with the sensate focus and on to intercourse. As mentioned in a previous section, intimacy can be affected by vaginismus and many therapists used sensate focus techniques as a way for a couple to connect and to build up the intimacy gradually without the pressure of sexual intercourse and to improve their communication. During sensate focus, sexual intercourse is banned. Therapist Cian explains that the sex ban for couples who are not having penetrative sex can seem counter-intuitive at first but he explains it to them in the following way,

> You haven't [been having sexual intercourse] but you have been thinking about it all the time and it is always…causing you stress…they will come back in a week…they will say…'I actually felt so much more relaxed I the last week because [the pressure of sex] is not there.

This resonated with couples Medb and Alill, Niamh and Oisin and Macha and Cruinniuc, who explained that the ban on sexual intercourse had taken the pressure off and allowed them to concentrate on intimacy. Medb said, "We had to abstain from sex…it takes the pressure off…then we started trying [to be intimate in other ways]." Niamh thought that the advice they had had from a few of the professionals they had attended to "just step back from trying to have intercourse" was helpful because "it was becoming a bit tense and it was affecting our relationship, I think we were having more arguments then we needed to before we started going [to therapy]…[the current therapist] does emphasise to focus on if our relationship in general is good and that's what's important." Macha similarly said, "[The sex ban] was one of the best things that was ever recommended to us, definitely…just to learn how to have the [intimate] side of the relationship again because, we knew we wanted to be

together…so we knew we wanted that side of the relationship again.” Her partner Cruinniuc agreed saying, “being intimate without having sex was a huge help.”

Sensate focus is most effective, according to Therapist Boann, “as a time that they are going to work together to connect.” Eva’s partner Lir said that “Half of it is connecting with somebody else but half of it is connecting with yourself as well.” Therapist Aengus said that working on intimacy can also reduce the loneliness that is often felt in the relationship and to help the partners to feel connected. The fear of failure and a tendency towards spectatoring in the sexual encounter can be a major stumbling block and according to Therapist Cian, can cause the couple to be “disconnected from the magnificence of the moment.” Deirdre described it as, ”a sense of losing my breath, like my tummy just kind of felt like, kind of butterflies but not in a good way, I go, oh no, here we go again, this probably is not going to work.” Family Doctor Flidais said, “What you are trying to do is bring them back into their body because sex is a whole body experience so you need to connect.” Sensate focus can help to teach couples to deal with potential setbacks during the sexual encounter. Therapist Danu explains:

> You are asking the partner to be her team mate…watching them for their reactions to what you are doing, the partner may pick up that she has gone tense or into her head before she even notices because it is normal for her to do that…And they just slow down, she knows what to do if she gets fearful, and he facilitates that in his arms. There is cuddles, there is love…I get them to figure out what she needs to hear from him…I love you I think you are beautiful, it doesn’t matter if we don’t have sex….So they are not breaking the embrace and they are not having a failure. This is the important thing.

For Deirdre and Naoise, sensate focus brought a number of benefits. As explained above, some women do not enjoy touching their own bodies and this was Deirdre’s experience. Deirdre did not enjoy the self-focus part because she had to continuously try to calm herself down in order to try to insert her own fingers. For her, it was preferable that her

partner was with her and inserted his finger because, "I'd be more in the zone and I could kind of figure out what I need to do whereas if you are doing it by yourself, you are kind of putting the finger in and you are trying to calm down at the same time." Even though they had not had intercourse yet, they said that they were enjoying being intimate together. However, Therapist Danu said that it is important that the partner understands that they are not in control of the session because, "They have tried to jam a finger in…men who are anxious still do that. Men who are worried still that they are supposed to be taking control." In the case of couple Eva and Lir, after being to a family doctor for advice on dilator therapy, Lir took it upon himself to do a schedule and to oversee his partner's progress. Eva said, "It was very much like Lir's journey through me, not me on my own, so we ended up then going to a therapist." However, having been to sexual and relationship counselling, she said, "If we had been able to have sex straight away…we might not have talked about things as much….it has helped us connect on other levels as well."

By the time the couples are ready to try sexual intercourse, "There is a whole load of permission-giving, there is a whole load of sensitive touching, trust built hopefully by that stage" (therapist Fodla). One of the most important elements for the women in this study was that many were having difficulty putting complete trust in their partner, that they would stop in the sexual encounter as soon as they asked them to, and this was also beneficial for the partner. Grainne's partner Diarmaid explained, "If you are taking more of a passive role you are not worried so much about [hurting her]…it always would be because you are obviously thinking about how the other person is feeling…that would be a concern." Deirdre's partner Naoise said, "We have an understanding that if there is a problem Deirdre is going to tell me so I don't think about [hurting her]…that kind of agreement is important too."

Macha and Cruinniuc said that they managed to eventually have sexual intercourse because they, "had gotten used to being intimate." Some therapists said that generally once the vaginismus is resolved it does not recur unless there is a further difficulty such as a

traumatic birth. Therapist Etain said that the treatment for vaginismus for a couple with a reasonably good relationship to start with often brings couples closer because there is better communication. Therapists Danu and Bebhinn said that it teaches couples not only practical sexual skills but also what to do when they have a potential future setback. Macha and Cruinniuc said that when they had had babies it can take a little while to get back into it after not having sex for months but eventually they prioritised sex again and felt they had learned the skills to deal with it. Couple Liadain and Curither said that they had learned life skills to deal with any future setbacks. Lir said "I feel like the stuff that we have learned will kind of last the rest of our lives."

It is also important that the couple understand that a successful outcome means more than penetrative sex. Therapist Banba said, "the outcome measure is that the client is satisfied with the result; that they have a sexual relationship that they are happy with…that is pleasurable, that it is pain-free is the main thing…that it is mutual, enjoyable." According to therapist Boann, in order for sex therapy to work the couple, "need to be connected… and to be just viewing it as ok this is a challenge that's here and we both have to approach it." Family doctor Ernmas said that the ones who were successful had partners that would, "Love them regardless of whether or not there is physical sex until it is sorted. Love them for their being, for their soul, their heart." Therapist Cian said, "I want them to be loving, it's a normal part of their relationship…we don't love each other for sex. Sex is the celebration of our love…it's a natural sexual expression of our emotional intimacy."

Healing Connection Through Relationships Section Summary

Despite the experience of vaginismus, relationships for couple participants in this study were typically robust and supportive and vaginismus did not generally indicate deeper relationship problems. The couple can often find other mutually satisfying ways to be sexual within the relationship. At some point in the relationship, a decision may be made to work at

resolving the problem. Wanting to increase intimacy appears to be a more successful long-term contributor to a satisfying sex life than wanting to have children. Having a loving intimate relationship can be a way of connecting with disconnected aspects of the self and to give permission for the emotional and sexual aspects of the self to emerge in a supportive loving relationship. Some couples managed to resolve the vaginismus themselves by gradually increasingly their intimacy. However, with regard to the couples interviewed for this study, the couples who had managed to resolve the problem by themselves had secondary vaginismus and had previously had an enjoyable sex life.

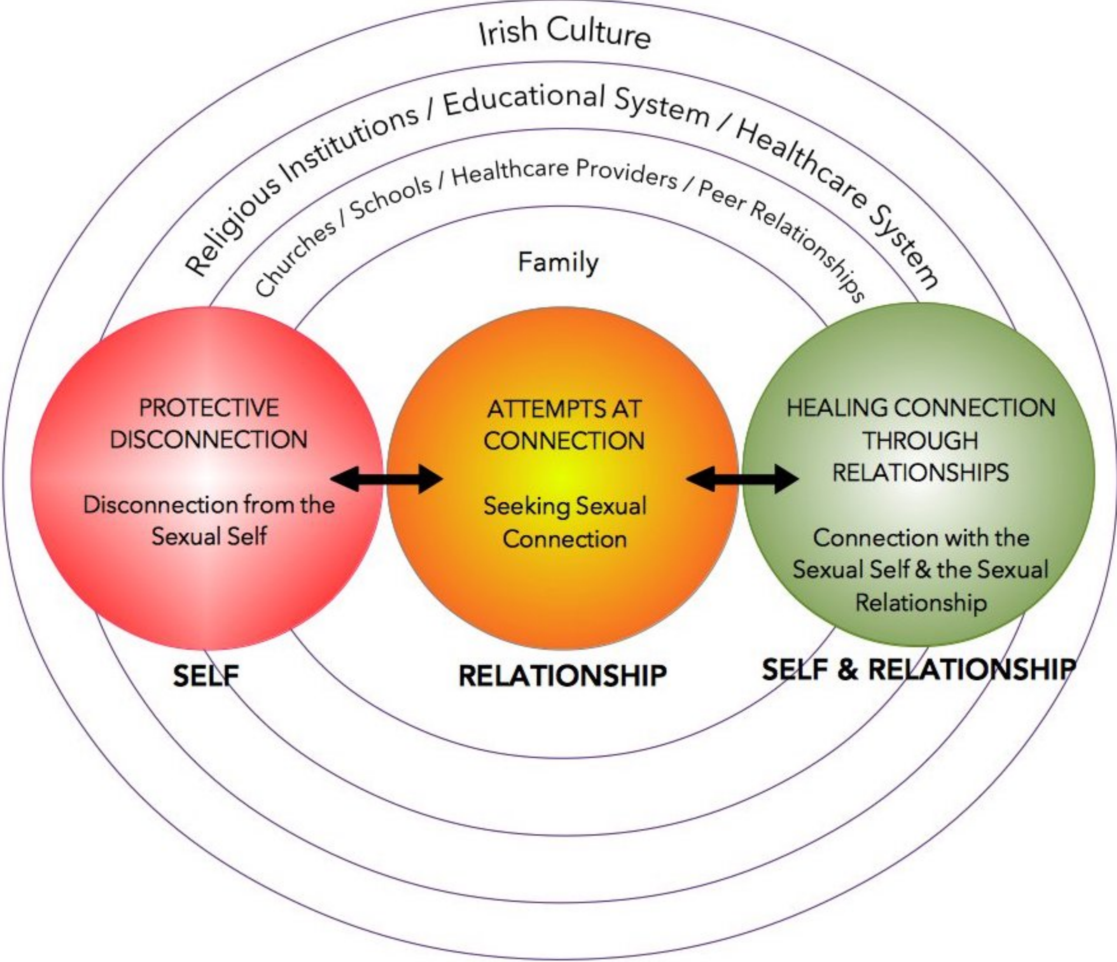
For couples who were unable to resolve the difficulty by themselves, the services of a therapist were sought to support their progress. Going for therapy can help to open the conversation about and understand the psychological components of vaginismus and the connection between thoughts, feelings and the body. The process of sensate focus can facilitate cognitive and behavioural change. Sometimes women are reluctant to attend psychological therapies because they feel that it will take too long and want to fix the problem quickly. However, understanding the role of psychological processes can be the start of a personal journey for both partners supported by the encouragement of their therapist. Within the therapeutic setting, the couple can also start to understand vaginismus as a couple problem to be resolved together. The process of engaging with the therapy can lead to improvements in emotional and sexual communication and strengthen the relationship and to provide empowerment by teaching skills to deal with any sexual or relationship difficulties.

Whether resolved in the relationship between the couple themselves or by attending a supportive therapist, for the couples interviewed in this study, resolving vaginismus is not just about being able to be sexually intimate but a chance for both partners to connect with their emotional and sexual selves, to move beyond the shame and fear instilled by cultural and familial messages and to take ownership of their relationship as mature sexual adults and intimate loving partners.

Disconnection and Connection: A Developmental Theory of Vaginismus in the Irish Context

The sub-core categories outlined in the chapter are presented in the following diagram to illustrate a developmental theory of vaginismus in the Irish context. From the data, a pattern of the experience emerged from protective disconnection from the sexual self that predated engaging in adult intimate relationships, to attempts at seeking sexual connection in an adult intimate relationship and attempts, to healing connection through relationships and connection with the sexual self. Figure 3 illustrates the third and final phase of the development of the theory of vaginismus in the Irish context.

Figure 3: Disconnection and Connection: A Non-Linear Developmental Theory of Vaginismus in the Irish Context



This substantive theory of vaginismus represents the experiences for women and couples specifically within the context of Irish culture, mediated through national and local institutions and more powerfully by Irish family dynamics. It is important to note that not all women will experience all of these elements but a blend of these factors may feature prominently in the lives of Irish women and couples who experience vaginismus. This conceptualisation of vaginismus as a developmental theory represents a journey that women and couples make to connect with the sexual self within the context of a sexual relationship within a particular cultural context.

The aim of this study was to examine the phenomenon of vaginismus in the Irish context in order to develop a theoretical framework of the experience of vaginismus and help-seeking for Irish couples. The theory that emerged was a developmental theory, characterised by experiences of both disconnection and connection. The three processes of the developmental model progress through early experiences in the family of origin that contribute to the vaginismus, to early experiences in adult intimate relationships and attempts at help seeking that prolong the vaginismus, to experiences that can help to resolve the vaginismus. The first process describes the experience of protective disconnection, including the development of vaginismus, in the context of growing up in a family where parents are unable to make emotional connections and hold a restrictive view of sexuality. The second process involves often unsuccessful attempts at emotional and sexual connection within an intimate relationship and unsatisfactory attempts at reaching out to healthcare providers. In the third process, positive experiences in the intimate relationship and the therapeutic relationship can foster healing connection with the emotional and sexual self.

The first process in the theory has its origin in childhood. The developing self experiences a lack of emotional support from caregivers and in that context a sense of self can develop that is focused on pleasing others and denying one's own emotional needs. At puberty, sexual matters are perceived as confusing and threatening and the sexual self that is

emerging at that time is similarly experienced as confusing and threatening. There can be a perceived necessity to protect the self by disconnecting from emotional and sexual needs. In the second process in the theory, the woman enters into a couple relationship and attempts to connect with the sexual and emotional parts of herself. Initially, a sense of disconnection and confusion can be experienced when seeking answers about the presence of vaginismus. The intimate relationship may be experienced as emotionally challenging for the couple who are trying to make a sexual connection when vaginismus is a concern. Accessing accurate information from outside sources tends to be hit and miss, which adds to the confusion around sexual matters. In the third process, which focuses on the resolution of vaginismus within the intimate relationship, the couple experiences the relationship as a way of connecting with disconnected aspects of the self, including the sexual self. For some couples, the relationship itself will facilitate experiences of connection. For other couples, the challenge may be too great to solve the problem within the relationship and they may utilise therapeutic healthcare services as a way for both partners to connect in the relationship, to each other, and to their sexual and emotional selves.

It is important to note that this process is not meant to represent a linear model as not every woman and couple would experience and move through all three processes. Women who disconnect from their emotional and sexual selves may never be able to make the step to enter into intimate relationships. Alternatively, they may enter into relationships but leave when emotional and sexual intimacy feels threatening and so do not progress to the second process of being in an intimate relationship. At the second process in the model, couples in an intimate relationship may experience profound emotional and sexual difficulties in an intimate relationship arising from vaginismus. They may stay in the relationship but use emotional and physical avoidance to avoid the pain and frustration experienced. Alternatively, they may actively seek help, but when that help is not forthcoming or unhelpful they may stop trying, believing that the issue cannot be resolved but decide to stay in the relationship. Often,

these couples will find their own way to be sexual, and may have a satisfying intimate relationship but may lose hope that anything can be done to tackle the vaginismus or achieve sexual intercourse. Some couples may move to the third process, persisting in finding answers. Some may find the resolution to the problem through a natural progression of their intimacy and a deepening trust over time but for others the endless attempts at failed intercourse and move them back towards avoidance. For many couples, therapeutic relationships can provide important emotional and practical support when attempting to directly deal with the vaginismus, and part of this support is building in a contingency plan for setbacks that might occur. If there is a disconnection in the therapeutic alliance, the couple may retreat back to a previous process of avoidance. Therefore, the process model presented contains a number of pathways that can represent the varied experiences of women and couples experiencing vaginismus.

All of these experiences are taking place within a multi-level context, represented by the concentric circles in Figure 3. The first (outer) circle that influences the entire process represents cultural norms and values, as well as institutions and policies. Aspects of Irish culture such as the legacy of the Christian Church on cultural attitudes to sex and on educational and medical practices are contained at this level. The second circle represents national institutions that translate the cultural values through religious, educational and medical institutions, such as denominational schools, the Department of Education and the Health Service Executive (Republic of Ireland) and National Health Service (Northern Ireland). The third circle represents the local institutions that translate cultural values in a direct way in churches, classrooms and family doctor surgeries. The third circle also represents the social relationships outside of the family, including teachers, family doctors and peer groups that can mediate these cultural values in positive and negative ways. The fourth (inner) circle represents the family of origin, often the main facilitator for the transmission of cultural values to the individual.

These levels of context that surround the woman can influence her emotional and sexual development and her experience of intimate relationships. However, this influence should also be seen as a dynamic one, especially at the level of the third (local institutions and social relationships outside of the family) and fourth (family) where relationships are often negotiated in dynamic experience. As previously stated, not every girl in the family will develop vaginismus and so it is important to consider the dynamic relationship between this particular girl and her particular family within a particular cultural context that might contribute to the difficulty. Similarly, interactions with religious, educational and medical personnel as well as peer group relationships vary with different people experiencing these interactions from different perspectives.

The experience of vaginismus outlined in this study is one of disconnection and attempts at connection with the emotional and sexual self within a developmental framework. The woman, and later the couple, move through a three process that includes protective disconnection, attempts at connection and healing connection through relationships. This non-linear interconnected process takes into account the experiences of women and couples experiencing vaginismus within a context of particular Irish cultural, national and local influences. The person and the process is surrounded by layers of context that influence the central process, some of which are peculiar to the Irish context and some that are more universal. The next chapter will discuss the unique contributions of this new theory of vaginismus and will consider implications for theoretical understandings and for practice.

Chapter Five: Discussion

The preceding results chapter outlined the substantive theory of disconnection and connection as a way of understanding vaginismus as a developmental process within a particular cultural context. This chapter outlines the key ways in which this theory makes an original contribution to current theoretical understandings of vaginismus and approaches for practice. The findings of this study are compared with existing theoretical and practice literature, acknowledging the similarities and highlighting the key differences that make this perspective on vaginismus unique. The original contributions to theoretical and practice literature on vaginismus are summarised under three key themes. First, vaginismus can be reframed from a dysfunctional sexual difficulty to an adaptive response to unmet emotional needs in a particular familial and cultural context, with consequences for the development of the self, including the sexual self, and sexual relationships. Second, the couple relationship, while bringing its own challenges, presents an opportunity for healing. Third, the findings suggest that a holistic response to women and couples experiencing vaginismus is indicated. This conceptualisation of vaginismus presented in this chapter broadens current discourses and has implications for enhanced understanding more sensitive approaches to the treatment of vaginismus.

Vaginismus as an Adaptive Response to Unmet Emotional Needs in the Family of Origin

This study has identified a developmental pattern of experiences of unmet emotional needs in the family of origin as a dominant theme contributing towards vaginismus. For the participants of this study, emotional communication within the family was perceived as restrictive. Parents were experienced as unable, for various reasons that may include their own perspectives or ability in engage with relationships and sexuality, to care fully for their daughter's emotional needs in general, and particularly her developing sexual needs around the time of puberty. The data presented in this study redefines vaginismus as an adaptive

coping response to growing up in a family environment characterised by perceived unmet emotional needs. This section looks at the experience of unmet needs and the consequences for the development of the self, the corporeal and sexual self and the relational self, in order to understand how unmet emotional needs in childhood can lead to the process of protective disconnection and the development of vaginismus.

Perceived Unmet Needs and Emotional Dysregulation

The first process in the theory outlined in the previous chapter, protective disconnection, describes the experience of a sensitive child growing up in a household where parents provide few demonstrations of affection and are perceived to be unable support her emotional needs. According to the participants, there was little evidence of emotional or physical intimacy in the household. Parents did not appear to have close intimate relationships with one another and did not model affection in the home. They were often described by the participants as practical, rather than emotional in their approach, caring for the basic needs of the family, but were not portrayed as being equipped to deal with the emotional needs of their children. For example, some expected their young daughters to deal with adult situations by themselves, when their intervention and support would have been more appropriate. Fathers were frequently physically as well as emotionally distant from the family. In some cases, mothers were struggling with their own mental health difficulties that impacted on their ability to be emotionally present in their daughter's life and to provide her with emotional support.

Developmental theories including object relations theory, attachment theory and regulation theories provide an understanding of growing up in households where emotional needs are unmet. Donald W. Winnicott's object-relations theory (1965) of ego distortion asserts that progress towards an independent self is facilitated by good enough conditions, which are provided by a responsive, empathic and reliable mother figure who can respond to

the infants pre-verbal attempts at spontaneity with encouragement and sensitivity to the child's needs. From these good enough conditions, the ego is strengthened and the true self can evolve. When a good enough caring environment is lacking, the failure of care constantly disrupts the continuity of being, preventing integration and producing a pattern of "fragmentation of being" and the development of the false self (1965, p. 60). According to Winnicott (1965), when the continuity of being is constantly interrupted by environmental impingements from which the infant does not receive protection, the result is unmanageable anxiety. Although this theory is now more than fifty years old, Winnicott's ideas have been supported by more current attachment and neuroscientific research that elucidate the biological and psychological mechanisms by which unmet emotional needs can contribute to emotional dysregulation (A.N. Schore, 2005; J.R. Schore & Schore, 2008).

Attachment literature has highlighted the role of maternal sensitivity in synchronous and reciprocal mother-child interactions to develop secure attachment bonds (J.R. Schore & Schore, 2008). Attachment refers to "an affectional tie that one person…forms between himself and another specific one…that binds them together in space and endures over time" (Ainsworth & Bell, 1979, p. 50). Relationships with parents that are characterised by neglected emotional needs are usually classified as an insecure attachment, anxious-ambivalent type (Schimmenti & Bifulco, 2013). The anxious-ambivalent attachment relationship in childhood is classified in adulthood as a preoccupied style of attachment that is characterised by viewing the self in negative terms and unworthy of love (Bartholomew & Horowitz, 1991). Research by Schimmenti and Bifulco (2013) has linked emotionally cold parenting to an anxious-ambivalent attachment style and the development of anxiety in emerging adulthood. Holmes (2000) clarifies, however, that the felt experience is not an anxious, avoidant or ambivalent attachment bond per se, but rather the self in relation to another. The availability, reliability and supportiveness of attachment figures determines

whether the attachment is perceived by the infant as secure or insecure and creates a mental representation of the worthiness of the self and the trustworthiness of others (Bowlby, 1973).

J.R. Schore and Schore (2008) propose a regulation theory that they describe as, "an amalgam of Bowlby's attachment theory, updated internal object relations theory, self psychology, and contemporary relational theory all informed by neuroscience and infant research…a profoundly developmental approach" (p. 17). Regulation theory focuses upon the mother-child interaction in the development of the brain systems of the right hemisphere that underlie attachment and development. The infant's and mother's right hemisphere interact in the mutual processing of nonverbal dyadic attachment communications (J.R. Schore & Schore, 2008). The early maturing right hemisphere is deeply connected with the limbic system and vital to the control processes involved in the regulation of emotion (Buchheim et al., 2006). Emotional communication allows for the caregiver to act as a regulator of the child's arousal levels (A.N. Schore, 2000). Moments of dyadic face-to-face emotional transactions known as "affect synchrony" allow the mother to appraise and regulate the infant's internal states, increasing the infant's ability to regulate affective states (A.N. Schore, 2005, p. 206). According to J.R. Schore and Schore (2008), mature emotional development can, therefore, be facilitated or inhibited by early relationships with caregivers. The authors further suggest that emotional misattunement has a negative impact on the maturation of brain regulatory systems and can disrupt the attachment bond.

When emotional needs are unmet, the infant feels unsafe and ongoing feelings of threat lead to a dysregulated, hyperactive and prolonged stress response (Sbarra & Hazan, 2008). The hyperactivation of the sympathetic nervous system due to a failure of the attachment relationship can lead to a depleted and dysfunctional stress response system and an increase for stress-related psychopathologies such as chronic anxiety disorders (Nolte et al., 2011) and psychosomatic disorders (J.R. Schore & Schore, 2008) including vaginismus (Weijmar-Schultz et al., 2005). The theme of overwhelming anxiety was dominant in the data pertaining

to identifying those most vulnerable to developing vaginismus. In this study, all of the professional participants and all but one of the couples mentioned anxiety as being a concern for women with vaginismus. This anxiety frequently manifested in the body as extreme forms of tension that extended to the vaginal muscles. Studies have made strong links between anxiety and vaginismus (Farnam et al., 2014). Women with vaginismus have been found to score higher on tests of general muscle tension (Basson et al., 2004; Lahaie et al., 2015) anxiety (Watts & Nettle, 2009) and stress (Bodenmann et al., 2006). The research supports the conceptualisation of the vaginismic spasm as part of both the wider defence reaction of the body to stress (van der Velde & Everaerd, 2001) and a hyperactive, prolonged reaction to stress (Frasson et al., 2009).

Some of the women interviewed said that their anxiety extended into other areas of their lives but for others the anxiety and tension centred specifically around the sexual encounter. Many professional participants suggested that, for women with a generally anxious approach to life, tension in the body often mirrored intrapersonal emotional tension and interpersonal tensions within the family. In the couple interviews, three of the women attributed their anxiety to difficult relationships with their mothers growing up who were also described as having their own emotional difficulties and being unable to meet their daughter's emotional needs or to support them during times of difficulty. The literature suggests that emotion dysregulation in childhood is associated with insecure attachments and feelings of vulnerability that can manifest as extreme forms of anxiety somatised as widespread muscle tension. These studies lend support to the understanding of vaginismus as a functional spasm that is part of a wider defensive system that protects the woman from perceived harm. In line with the developmental theories discussed in this section, this study also found that the experience of a lack of parental affection and unmet emotional needs was common in the childhoods of those who were vulnerable to developing vaginismus. The manifestation of extreme forms of anxiety was a dominant theme throughout their lives.

In order to protect herself from the pain of unmet emotional needs and to manage this anxiety, the data in this study suggests that the women frequently had to disconnect from her feelings and needs and this has implications for the development of the self, the sexual self and the relational self. Each of these themes are explored in the following sections.

The Consequences of Unmet Emotional Needs for the Development of the Self

> If you have that type of parenting experience early on that has been either inconsistent or absent, you take in something about that about yourself of not being good enough…something like that just kind of gets buried…how do you fix that…cover up for that…fix yourself ultimately? (therapist Beibhinn)

Being sensitive to feelings of shame and hurt was identified as a risk factor for developing vaginismus. In this theory, it is proposed that sensitive daughters are more likely to internalise messages from childhood in a particular way that produced a sense of shame. When emotional needs are not met, the daughter may seek approval from parents by denying her own emotional needs and putting the needs of her family before her own. There is evidence in the data that many women with vaginismus take on the worries of the family even as children and try to behave in such a way that does not present any further difficulties for the family. In order to protect herself from personal shame and from shaming the family, the woman appears to disconnect from her emotional needs and to increase control over her own behaviour. For a woman with unmet emotional needs, a sense of control can be an important defence mechanism to protect the self from feelings of anxiety and shame and hurt. The more control she asserts over her own emotions and behaviour, the less likely she is to invite shame or cause problems for the family.

According to Kohut (1972), a lack of empathic mirroring from the mother leads to an experience of disapproval and intense shame for the infant. Experiences of empathic misattunement can result in feelings of failure and shame and perception of the self as

inadequate (Spiegel et al., 2000). Emotion dysregulation has biological, psychological and social consequences. In addition to playing an important role in emotion regulation, the early maturing right hemisphere is vital in 'maintaining a coherent, continuous and unified sense of self' (Devinsky, 2000). The sense of self originates out of an interpersonal context between mother and child (Holmes, 2000), and when the emotional relationship is misattuned, the infant experiences herself as confused, helpless and deficient and the self is perceived as an object of shame (Spiegel et al., 2000). The infant is left alone to cope with unmanageable dysregulated mood states (Pearlman & Courtois, 2005). According to Winnicott (1965), the false self, needing to integrate but having no support to do so, is constantly restless and is always trying to put something right. In order to gain approval from caregivers, the false self disconnects from emotional needs and imitates the behaviour of others, complies with their wishes and exerts control over feelings and behaviour, leading to the development of the caretaker self. Winnicott's theory resonated with the experiences of some of the women interviewed for this study who discussed managing their anxiety with the use of meticulous planning and the application of strict moral standards and codes of conduct on their behaviour to avoid potentially letting down or shaming themselves or their family. According to the professional participants, the woman may place rigid controls over her emotions and behaviour in order to protect herself from potential shame and hurt and the loss of parental approval. The loss of control was experienced as intensely distressing. The data suggests that protecting oneself from disapproval and shame ultimately necessitates disconnection from one's own emotional needs in order to prioritise the needs of others and to survive in a household where emotional expression is perceived as not being supported.

In both the professional and couple interviews, many of the participants spoke about the mother's emotional difficulties that often resulted in an inability to fully care for the needs of her daughter. In some cases, this inability may have led to a reversal of mother-daughter roles. In some cases, mothers turned to their own daughters for emotional support or expected them

to behave in a way that would not engender any potential difficulty or embarrassment for them or the family or to take on adult responsibilities. When emotional needs are unmet, the daughter continuously seeks approval from her mother by prioritising her needs, or the needs of the family, and disconnecting from her own. A. Miller (1979) states that the emotionally insecure child intuitively responds and emotionally adapts to the needs of the mother (or parents) who are similarly emotionally restricted. This adaptation may necessitate disconnecting from emotional states in order to maintain equilibrium in the household.

Mothers who did not receive nurturance and guidance from their own mothers are unlikely to be able to provide nurturance and guidance to their own daughters (Litton Fox, 1980). Eichenbaum and Orbach (1982) propose that when the mother's needs are unmet, there are two outcomes for mothering. First, they deny their daughters' needs as part of their own self-denial, and second, they turn to their own daughters to provide for their own unmet emotional needs. The writings of feminist psychoanalytic writers such as Chodorow, Dinnerstein and Miller state that the identity of mothers and daughters is dyadic and continuous and depends upon the quality of the early mother-daughter relationship (Hirsch, 1981). When the daughter is socialised as a nurturer of others and role reversal occurs, "her first child is her mother" (Eichenbaum & Orbach, 1982, p. 39). When this role reversal occurs, the attachment bond is disrupted and reassurance is elicited from the infant (Lyons-Ruth et al., 2004) and the daughter may learn from a very young age, possibly in the first year of life, to be highly attuned to her mother's moods and to engage in a compulsive caretaking role (Holmes, 2000). According to Hilburn-Cobb (2004) these submissive strategies, rather than increasing the child's independence, facilitates the caregiver's dominance as efforts at caretaking and approval seeking are frequently responded to with criticism from the parent. Such experiences for the child are associated with rumination on childhood events, feelings of guilt and unresolved emotional relationships with parents.

One of the priorities of the Irish family identified in the data was the avoidance of shame related to the sexual behaviour of their daughters. The girl may also prioritise this as a way of caring for the needs of the family above her own needs to be sexual. As well as disconnecting from her emotional needs, she may also disconnect from her body and from her evolving sexual needs. This disconnection has a protective function; by distancing herself from her own emotional and sexual needs and prioritising the needs of others, she is protecting herself from disapproval, shame and hurt. The following sections explore the explicit and implicit messages from the family and from culture about sex and sexuality that may provide the conditions for disconnecting from the sexual self.

The Role of the Family and Culture in Affecting the Development of the Sexual Self

All participants in the study identified aspects of Irish culture as being significant in forming negative attitudes towards sex and sexuality. Historically, Ireland was identified by the participants as having a particularly strict moral code characterised by embarrassment around sexual matters that seemed to pervade Irish culture even to this day. The legacy of the Christian churches both North and South of the Irish border were discussed by participants as significant in the active suppression of sex education in Irish schools and formation of shameful attitudes around matters of sex and sexuality throughout society. Although some of the participants mentioned a move toward a more general liberal attitude towards sexual matters in modern Irish culture, the data indicates that, for the clients of the professional participants interviewed and the couple participants in this study, liberal attitudes to sex and sexuality did not feature in their upbringing.

The Irish family was experienced by participants in this study as being very sensitive to shaming of any kind, but that sexual shaming seemed to be particularly disconcerting and often this shame was related to the sexual behaviour of the daughters in the family. Many of the participants mentioned church teachings having contributed to the sense of sexual shame

and, in particular, the shame of a woman's sexual behaviour or pregnancy outside of confines of marriage. Typically, sex was usually not discussed in the family, but any messages about sex were delivered directly or indirectly were experienced as engendering shame and fear and encouraging the suppression of sexual feelings and abstinence from sexual behaviour, especially for daughters. The women interviewed recalled that any messages they received about sex were predominantly negative, including frightening messages about the pain of sex and the untrustworthiness of men and shaming messages about pregnancies outside of marriage. The discussion of sexual problems including vaginismus were experienced as shameful and this prevented any discussion of sexual difficulties with family or with friends.

Regulation theory portrays attachment as a product of an individual with a particular temperament in a relationship with caregivers in a particular culture. "…individual development arises out of the relationship between the brain/mind/body of both the infant and caregiver held within a culture and environment that supports or threatens it" (J.R. Schore & Schore, 2008). Previous Irish studies of the aetiology of vaginismus in Ireland by OSullivan (1979) and Barnes (1986b) highlighted negative sexual conditioning that involved religious themes related to Catholicism as contributing factors to the high rates of vaginismus found in Ireland compared with the rest of Europe. These themes included strong conservative attitudes towards any expression of sexual feelings including sexual pleasure within the marital relationship (OSullivan, 1979). The primary source of this morality was always found to be the home, usually from the mother, and contributed to sexual anxiety and higher rates of vaginismus than the rest of Europe (Barnes, 1986b). Although a study of Irish university students by Malesevic (2003) suggested that Irish attitudes to sex and sexuality were no longer predominantly conservative, a study in Northern Ireland by Rolston et al. (2006) stated that a particularly traditional and conservative form of Christian morality was still in evidence. In the Republic of Ireland, an assessment of the RSE curriculum found that its delivery was still being constrained by a predominantly Catholic ethos in state schools

(Mayock et al., 2007). A recent phenomenological study of the impact of religiosity on a woman's sexuality found that faith based implicit and explicit messages about sex and sexuality increased feelings of shame and a disconnection from the sexual self and from the body (Burton, 2017).

Despite the communication difficulties that participants highlighted in their family of origin, there was also evidence at some attempts by parents to broach the subject of sex or periods, even though it was often limited to biological aspects and frequently contributed to further feelings of confusion and shame for daughters. None of the women interviewed for this study recalled having a particularly deep conversation with their mothers about entering puberty or menstruation and some felt that they could not bring up the subject at all. According to the participants, the messages they received from the family were experienced as shaming and threatening. The participants experienced feelings of shame around touching or looking at one's own body and tampon use was often expressly forbidden. Men were portrayed as untrustworthy; using women for sex and deserting them if they got pregnant. Pregnancy outside of marriage was spoken about in the context of bringing shame on the daughter and shame on the family.

A systematic review of qualitative studies of the experiences of puberty in the U.S. by Herbert et al. (2017) found that generally girls recalled their experiences of going through puberty as negative. Mothers were cited as the most important source of information and support but many of the girls reported feeling disappointed with the information they were given. Similarly, the women interviewed for this study said that they had been given inadequate information around the time of puberty to prepare them for menstruation including little information about hygiene products and some had been afraid to bring up the subject with their mothers. The time surrounding puberty and menstruation can provide an opportunity for mothers and daughters to share common experiences and to relate to one another in new ways (Gillooly, 2008) but mothers who feel threatened by this transition may

not only avoid the conversation but instead use scare tactics to regulate their daughters' behaviour (Herbert et al., 2017). Ward and Ogden (1994) identified family factors that had contributed to vaginismus and these included ridicule, inappropriate suggestions and confused feelings around sexuality. Herbert et al. (2017) found that mothers tended only to discuss the sexual aspects of puberty in terms of frightening messages about male predatory behaviour and unwanted pregnancy, leaving their daughters feeling scared and unprepared for sexual relationships. Similarly, the women interviewed for this study stated that the discussion of sex and sexuality was largely forbidden and any communication that did take place tended to centre on the shaming and frightening consequences of sexual behaviour. A report by the Irish Crisis Pregnancy Agency revealed that communication between parents and daughters about sex was characterised by feelings of unease, regular and consistent warnings about the negative aspects of sex, and rigourous monitoring of their behaviour (Hyde & Howlett, 2004).

King and Lousso (1997) found that parents and their university-aged children had different perspectives on discussions about sex in the home. The majority of parents recollected the discussions as meaningful, but less than half of their children agreed. A qualitative study identified "not knowing how to talk to their children about the subject" was one of the main barriers for mothers in discussing sex with their children (Wilson et al., 2010, p. 56). The parents also tended to equate sexual knowledge with a destruction of their children's innocence and increases in readiness to engage in sexual activity. Similarly, a report on the provision of sex education in Ireland found that a small number of parents concerned that providing information about contraception would be interpreted by children as consent to have sex (Mayock et al., 2007). The students surveyed for this report disclosed that speaking about sex with parents was embarrassing and often of limited value. Wilson et al. (2010) suggest that parents should be educated and supported to reframe sexuality as a healthy part of human development and sex education as contributing towards sexual safety and well-being. Shtarkshall et al. (2007) advise that, although parents can provide social,

cultural and religious values about sexual relationships, it is perhaps more appropriate that health and educational professionals play a primary role in proving factual information about sexuality and developing mature social skills for negotiating relationships.

The data in this study showed that not only was there an absence of or inadequate sex education in the home, there was also very poor sex education provided in schools. Many participants commented that, in their experience, the sex education they received did not extend beyond the mechanics, that female anatomy was not part of the curriculum, the emphasis was on procreational aspects and that there was no discussion of sexual pleasure. Historically, the influence of the Christian Church in Irish state schools has resulted in an active suppression of accurate sex education in state schools (Ferriter, 2009; Ingles, 1998; Rolston et al., 2006). Sex education in Northern Ireland has been identified by Rolston et al. (2006) as conservative or absent and underpinned by a particularly traditional and conservative form of Christian morality. Despite the attempts of the Irish state to take control of sex education away from the church by developing a Relationships and Sexuality Education (RSE) curriculum in 1997, this curriculum was criticised for providing a narrow definition of sexuality that excluded sexual pleasure and desire (Kiely, 2005). As recently as 2019, a government report stated that the curriculum needed to be updated to reflect the changes in attitudes toward sex that have taken place in Ireland (Oireachtas, 2019).

For participants, this restrictive narrative about sex extended outside of the family sphere into peer groups. The findings of this study indicate that few of the women felt comfortable enough to discuss sexual matters with their peers. Some women with vaginismus have been found to be much more socially inhibited and introverted than their counterparts, and this can create barriers to establishing intimate relationships with same sex friends, not only due to shame or the perception that others will not understand, but also due to a generalisation of the fear of personal boundaries being invaded (Ward & Ogden, 1994). For a number of the women in this study, the main reason was that they would view this disclosure

as a betrayal of their partner and of the privacy of their relationship. In contrast, some of the women had reached out to their peers for advice and support. Despite some studies finding that supportive peer relationships can be used during adolescence to offset insecure attachments at home, e.g. (Allen & Miga, 2010; Nickerson & Nagle, 2005), other studies indicate that only those who are securely attached in their family of origin feel confident enough to establish emotionally intimate peer relationships with friends in whom they can feel they can confide (Carr & Wilder, 2016; Sroufe, 2005). Whether peer relationships can offset poor attachment relationships in the home may have to do with the quality of the peer relationships. Allen et al. (2018) found that adolescents will only turn to peers to meet attachment needs if the relationship develops and deepens.

The quality of experiences of those participants who did chose to disclose about the vaginismus to a friend varied. Some of the women who had confided about their vaginismus to a friend noted that although the friend was sympathetic, they couldn't really empathise because they had not been through the experience themselves. One qualitative study found that vaginismus can create barriers to relationships with same sex friends because of shame, fears about privacy being invaded and perceptions of not being understood (Ward & Ogden, 1994). Similarly, another qualitative study found that embarrassment about painful sex prevented women from seeking support from their peers and that the women described themselves as "abnormal" and "damaged" because of their inability to talk about experiences of pleasurable sex with their peer group (Donaldson & Meana, 2011, p. 819). Other participants said that because sex was often perceived by peers as something that is natural and that everyone can do, when they confided in their peers that they had a sexual difficulty, it had been met with ridicule and awkwardness. Lyster (2012) has commented that the assumed sisterhood between women is a myth and interactions between women are characterised by casual bitchiness, gossip, comments and emotionally manipulative behaviour designed to pull other women down.

Because discussions about sexual difficulties were perceived as restricted in the family, among peers, at school the women were often left feeling that they were the only ones with the problem. The women often felt the shame of not being able to do something that was perceived as so easy and natural for everyone else. For some, the sense of shame pervaded many aspects of their lives. This negatively impacted their self-esteem and affected how they viewed themselves as women and as partners. The couple interviews revealed the loneliness, isolation and guilt experienced by those who are dealing with vaginismus.

The data from this study indicates that Irish culture may not provide the conditions for mature sexual development. These spheres of influence are represented in the diagrammatic representation of the theory outlined in the previous chapter as concentric circles surrounding the woman and later the woman and her partner. This representation draws on Bronfenbrenner's (1998) bioecologial theory and portrays the development of the individual within a number of social contexts: cultural, national, local and familial. The legacy of the doctrine of the Christian Churches on sexuality, combined with a cultural sensitivity to sexual shaming, restricts the discussion of sexual matters, including the provision of accurate sex education in schools. This restrictive attitude towards sex extends from the wider culture to the personal spheres of family and friend relationships that compounds the shame of sexual difficulties and makes the women feel like they are the only one with the difficulty. The culture of silence and shaming around sexuality can have a significant impact on women with vaginismus, on their self-esteem and their view of themselves as sexual beings. This culture creates conditions in which that vaginismus is very lonely and isolating for those who experience it. The consequences for the development of the corporeal and sexual self are explored in the next section.

The Consequences of Unmet Emotional Needs for the Development of the Corporeal and Sexual Self

The perceived absence of emotional support for daughters at a time when the sexual self is developing can lead to confusion and shame and cause conflict between the need to put the emotional needs of the family before her own developing sexual needs. Not only may it be necessary to disconnect from her emotional needs but, at the time of puberty, it may be necessary to disconnect from her sexual needs and from her own body in order to protect herself against sexual feelings, experienced as threatening to the self and to the family. Vaginismus provides a physical barrier that places a restriction on sexual behaviour and the potential for shame. This section explores the link between unmet emotional needs, the need for approval and consequences for the development of the corporeal and sexual self.

Many of the professional and couple interviews described very difficult interactions between mothers and daughters that intensified around the time of puberty and included shaming and threatening messages about sexual behaviour. A dominant theme in the couple and professional interviews was the shame surrounding a daughter's sexual behaviour. Growing up, shaming messages in the household regarding self-pleasure, sexual behaviour and pregnancy outside of wedlock were common. The idea of the woman experiencing sexual pleasure was often regarded as unimportant or abhorrent; sex was considered acceptable only for procreation within marriage. Men were often portrayed as not being untrustworthy, only wanting women for sex and being unable to curb their sexual desires. The responsibility for preventing sex and pregnancy outside of marriage was therefore put on the shoulders of the daughters, who were expected to restrict not only their sexual desires and sexual behaviours, but those of the men. If sexual behaviour or pregnancy did occur, the shame would be on her and her family. Many of the professional participants mentioned that their clients had been told that they would be thrown out of their home and would lose their family if they became

pregnant. None of the data indicated that the messages given to the boys of the household were similarly shaming.

Studies in Hong Kong by Ng (2001) found that mothers' negative attitudes towards pre-marital sex had a more profound effect on the development of vaginismus than religion for some women. The anti-sexual and pro-procreation scripts laid down by the family and culture were found to clash with the women's own sexual desires and contribute to sexual difficulties including vaginismus. In Ireland, Barnes (1986b) similarly found that women who most strongly identified with their mothers were more likely to develop an anti-sexual identity, to exert control over their sexual attitudes and relationships and to develop vaginismus. Many of the women interviewed recounted that messages about sex being painful and disgusting and the potential for their sexual behaviour to let down and shame the family frequently came from their mothers. This study found that the negative messages around sex and sexuality for girls were accompanied by perceived direct or indirect threats with the intention of scaring daughters into abstinence that included losing the love and support of her family and being thrown out of the family home. In this context, the sexual self can be experienced as threatening and anxiety provoking and in order to protect the self from shame or disapproval or rejection from the family, and in particular the mother, sexual needs may be repressed. In the words of Therapist Cian, the girl finds herself in the middle of, "a battle between trying to have her natural desire to be loved sexually," and "los[ing] her mother's love, her home," and "her natural defence is vaginismus." As previously stated, vaginismus functions as a protective safeguard against her natural sexual behaviour and potential shaming consequences in order to gain the approval and love of her family.

Object relations theory suggests that these messages to daughters, especially from mothers, may not only serve to curb their sexual desires but also to prevent them from growing into a mature independent sexual woman who may seek to establish her own intimate relationships outside of the family. Mothers who are deeply uncomfortable with

sexuality may respond with shock to the natural sexual instinctual behaviour of their child (A. Miller, 1979). According to Litton Fox (1980), during adolescence there should be a natural renegotiation of roles between mothers and daughters. The mother needs to relinquish her protective role and to become a guide for her daughter as she develops towards womanhood. According to this theory, mothers who did not receive such guidance from their own mothers and repressed their own sexual needs are more likely to use punishment and manipulation to disparage and increase control over their daughter's efforts to develop into a mature sexual woman. To prevent this separation, mothers increase pressure on their daughters to put the needs of others before their own, to feel guilty for their own desires and to suppress their unhappiness to protect the feelings of others. According to Chesler (1997) the need to retain control comes from the mother's fears that her daughter will separate from her not only physically, but also emotionally. For daughters, adolescence can be experienced as a time of emotional conflict between a need to retain familial closeness and the need to establish a separate identity, including a sexual identity. A study by Ruhl et al. (2015) found that increased criticisms from mothers around the time of adolescence was linked to fears of rejection from the mother and higher levels of anxiety.

According to Crittenden (2006), significant distortions of attachment are almost always involved in later distortions of sexuality. Fear of sexual intimacy is thus seen as rooted in an anxious-ambivalent attachment relationship in childhood and a preoccupied style of adult attachment which is underpinned by both fear of separation from and merger with another (Clulow & Boerma, 2009). The preoccupied attachment style in adulthood has been shown to correlate most frequently with vaginismus (Ciocca et al., 2014; Hamidi et al., 2015; Ozcan et al., 2015). With regard to fears of merging, according to Chodorow (1989), "feelings of inadequate separateness, the fear of merger are issues for women because of an ongoing sense of oneness and primary identification with mothers" (p. 108). Vaginismus, in this context, is a way of creating a barrier to protect the ego and prevent merger with a controlling mother

(Ward & Ogden, 1994). Vaginismus might also be a response to fear of intimacy originating from a feeling of abandonment by the mother and the protection against potential loss of an intimate other by avoiding intimate relationships (Arcelus & Wales, 2009). Ward and Ogden (1994) identified emotional distance in the family of origin as one of the factors that contributed to vaginismus.

The activation of the threat systems of the body due to the perceived dissolution of close protective bonds (Eisenberger, 2012) can explain the link between perceived rejection by parents and the development of vaginismus. As well as regulating the emotional and social self, the right hemisphere is also involved in the regulation of the corporeal self (Devinsky, 2000). Neurobiological data indicates that the right hemisphere is responsible for understanding ego boundaries, i.e. reference to non-self versus self (Devinsky, 2000). According to Winnicott (1965), one of the consequences of being prevented from naturally developing towards independence is an absence of relationship to the body because the limiting membrane of ‘me’ and ‘not me’ has not been established. A dissociation between mind and the body is necessary in order to maintain the false self and to deny one’s own needs. The true self comes from the “aliveness of the body tissues,” (p. 148) but a loss of integration between the ego and the body results in depersonalisation and dissociation from the body. Psychosomatic illnesses use the interaction of the psyche and the soma as a defence against depersonalisation. Bernstein (1990) suggests that if familial or cultural messages creates anxiety about crossing the body boundary before body integrity has been established, the girl may develop vaginismus as a psychosomatic defence in order to master this anxiety.

Disconnection from the body was one of the dominant themes that emerged from the data. Predominantly, the women in this study with primary vaginismus were reluctant to look at, to touch, or to explore her own body. Many of the professionals and women with primary vaginismus interviewed commented on the feelings of disconnection from their bodies, the lack of curiosity about exploring the body, and feelings of disgust regarding touching their

genitalia. For many of the participants of this study, the genital area was associated with actual pain conditions such as painful periods, endometriosis, irritable bowel syndrome, fibromyalgia and others that further led to feelings of wanting to disconnect from the pain associated with the genital area of the body. In a review of the literature by Graziottin (2008), vaginismus was frequently found to co-occur with other painful physical conditions. R.J. Brown et al. (2005) reported that patients suffering from somatoform pain disorders including fibromyalgia were more likely to have experienced early social trauma, suggesting that there may be a connection between socially painful experiences such as emotionally unsupportive family environments in childhood with later reports of physical pain. Eisenberger (2012) has identified the dissolution of close protective social bonds as one of the most distressing experiences a person can go through and is associated with an activation of the threat systems of the body to prevent social disconnection. He describes social pain as "the unpleasant experience that is associated with actual or potential damage to one's sense of social connection or social value (owing to social rejection, exclusion, negative social evaluation or loss)" (p. 421). The neurobiology of physical and social pain often overlaps, and has a broader role in the wider threat system in the body and processed by the same neural circuitry. The author goes on to suggest that socially painful experiences can be localised to a certain part of the body. In the case of the participants of this study, the genital area is associated not only with experiences of physical pain, but also with the threat of social shame and the loss of parental love and approval, and it is proposed, this could lead to a psychosomatic condition being localised to this part of the body, namely vaginismus. Defences, including psychosomatic symptoms, can be conceptualised from an attachment perspective as survival strategies to maintain interpersonal attachments when such relationships are threatened by suboptimal environments (Holmes, 2000).

The findings of this study represent vaginismus as a physical protective defence against the potential perceived negative consequences of sexual behaviour and the physical

manifestation of an emotional defence against the pain of unmet emotional needs. For a woman who has disconnected from her emotional, corporeal and sexual self because their emotional and sexual development was experienced as not supported, vaginismus can be understood as a protective defence mechanism to avoid feeling physical and emotional pain, to place controls over her sexual behaviour and to avoid shaming herself or her family and to avoid the social pain of their disapproval and rejection. The consequences of vaginismus for the development of the sexual, emotional and relational self in a mature sexual relationship is explored in the following section.

The Consequences of Unmet Emotional Needs for the Development of the Relational Self

According to the professional participants, the decision to enter into or to remain in a couple relationship is a courageous step that not every woman will take because it is considered emotionally challenging for someone who was brought up to perceive sex and sexuality as threatening and shameful. According to Donaldson and Meana (2011), the development of the sexual and relational self coincides with many other developmental transitions in adolescence including the consolidation of the self concept, relationship development and sexual exploration, and can be negatively impacted by experiences of painful intercourse at that time. Despite difficulties in making an emotional connection in family relationships, all of the women interviewed for this study had made the decision to enter into intimate relationships and to make an emotional and sexual connection with their partner. The need to deepen sexual intimacy and to be closer to their partners was the main motivator for women in this study to challenge and resolve their vaginismus.

According to a study by Ciocca et al. (2014), the lack of a secure base and feelings of insecurity in early childhood relationships was a negative predictor for the relational life and sexual functioning and a risk factor for the later development of vaginismus. Attachment theory suggests that those who were most securely attached in childhood have the most stable

relationships in adulthood and based on this theory, it would be predicted that those who experience a disconnected relationship in childhood would be unable to form secure adult attachments (Ainsworth & Bowlby, 1991; Hazan & Shaver, 1987; Hinde et al., 1982; Sroufe, 2005). Carr and Wilder (2016) suggest that insecure attachments styles at any age may inhibit help seeking and relying on the support of others during times of need. However, variations in attachment style seen in infancy are only initiating conditions that might continue under stable conditions or be deflected because of later experiences (Bowlby, 1973) such as the opportunity to have an intimate relationship (Holmes, 2000). Therefore, rather than viewing attachment as a stable characteristic of an individual it can be understood as a dynamic relationship negotiated between individuals within a particular relationship (Crittenden, 2006).

Unresolved attachment difficulties in childhood lead to the dysregulation of the attachment system and strong activation patterns in the emotion centres of the brain in adulthood (Buchheim et al., 2006). One such activating experience could be the opportunity to enter into an intimate relationship with a partner. Insecure attachment behaviours evoke responses from others that provide care, security and comfort (Stuart & Noyes, 1999), in other words to create secure attachments. According to Bartholomew and Horowitz (1991), the preoccupied attachment style (the attachment style most associated in the literature with vaginismus) is characterised by high anxiety but low avoidance. Therefore, rather than avoiding intimate relationships, those with a preoccupied attachment style in adulthood have been shown to be more likely to reach out to others for their dependency needs than other types of insecure attachment. Although many women do not, all of the female participants in this study who were or had experienced vaginismus were involved in committed long term intimate relationships despite the inherent challenges. Although it had been necessary when growing up in the family of origin to protect themselves from shame and hurt by disconnecting from their emotional and sexual feelings, the decision to enter into an intimate

relationship can be understood as their first attempt at making a connection with the emotional and sexual self. The intimate relationship can provide an opportunity not only for the woman to attempt to connect with her emotional and sexual self, but also to make an emotional and sexual connection with an intimate partner. The experience of attempting to make a connection in an intimate relationship is explored in the next section.

Section Summary: Vaginismus as an Adaptive Response to Unmet Emotional Needs in the Family of Origin

In summary, the findings of this study suggest that vaginismus is a meaningful psychosomatic symptom that has meanings far beyond the physical spasm. The data in this study indicates that vaginismus is a protective defence that is an adaptive survival response to growing up in a household where emotional needs are perceived to be unmet. Vaginismus can also serve as a protective defence preventing merger with a controlling other when the ego and the corporeal self lacks boundaries. Vaginismus can represent the clash between the cultural and familial messages around sexuality and a daughter's natural need to develop into a mature sexual woman. Vaginismus can also represent the struggle between connecting with sexual and relational needs and the requirement to disconnect from these needs in order to put the needs of others before her own. Finally, vaginismus can be understood as a protective defence that represents the necessity for sensitive daughters with unmet emotional needs to disconnect from these needs, from her body, and from sexual feelings, in order to protect herself from shame and the threat and social pain of disconnection from her family if their needs are not prioritised.

Implications for Theory

Some theorists have suggested that by expanding the definition of vaginismus beyond a medical perspective of vaginismus as a sexual dysfunction, there is an opportunity to

investigate the deeper emotional meanings behind the physical symptom (T. Rosenbaum, 2018; Shaw, 2001). In contrast to the medical understanding of vaginismus, behaviourists perceive sexual disorders as functional (Krueger & Piasecki, 2002), to protect the individual against actual, perceived or anticipated harm from vaginal penetration (Borg et al., 2012; Fugl-Meyer et al., 2012). Psychodynamic definitions widen this definition further, framing vaginismus as a psychosomatic expression of deeper intrapsychic conflicts about sex, e.g. Singer-Kaplan (1983). Object relations theory, rather than concentrating on the sexual relationship as the source of difficulty focuses on the mother-daughter relationship and, in particular, the difficulty inherent for girls in separating psychologically from the mother (Tugrul & Kabakci, 1997).

This study builds on these perspectives by identifying a particular developmental pattern of experiences in the family of origin that contributes towards vaginismus. The theory presented here takes a biopsychosocial perspective by combining the physical, psychological and social influences that contribute to vaginismus with a particular emphasis on the social and interpersonal factors, which hitherto have been the least explored by research (Atallah et al., 2016; Ng, 2010). This theory also aligns with the principles of developmental psychopathology defined by "attention to the understanding of causal processes, appreciation of the role of developmental mechanisms, and consideration of the continuities and discontinuities between normality and psychopathology" (Rutter & Sroufe, 2000, p. 265) in that this theory is not meant to be deterministic but one developmental pathway among many possible outcomes. For example, Eisenberger (2012) suggests that it is important for research to identify the pathways by which social pain becomes represented and localised in the body and the process of protective disconnection and the development of the vaginismic response described here contributes to such understandings.

The data presented here suggests that emotional communication within the family is perceived to be restrictive and parents are experienced as unable to fully care for their

daughter's emotional needs in general, and particularly her developing sexual needs around the time of puberty. In order to protect herself within an emotionally restrictive environment, it is perceived as necessary for the daughter to disconnect from her emotional, sexual and relational needs and to disconnect from her own body. A mixture of cultural and familial negative messages about sex as well as her own negative experiences may produce a psychosomatic symptom that focuses on the genital area of the body that protects her from emotional and sexual pain and shame, in this case, vaginismus. The data presented in this study redefines and extends the definition of vaginismus from a sexual dysfunction to an adaptive coping response to growing up in an environment characterised by emotional misattunement and sexual repression. The vaginismic spasm in this context can be understood as a protective mechanism for women, not only against the sexual encounter that they perceive as threatening, but also against the potential for experiencing disapproval and shame that has been associated with female sexual behaviour. The process of protective disconnecting explains vaginismus from a developmental perspective within a particular cultural and familial context and contributes a new theoretical understanding of vaginismus to the existing literature.

The Experience of Vaginismus in the Couple Relationship

This section discusses the experiences of couples in this study who were attempting to make a sexual connection in their relationship while experiencing vaginismus. Some of the couples had found ways to resolve the vaginismus within the couple relationship and others had not resolved the difficulty at the time of interview. The couple and professional participants describe experiences at attempting intercourse that can be on the one hand frustrating, painful and disappointing but on the other hand an opportunity to find other ways of having a fulfilling sexual relationship in the absence of penetrative sex. This section also

discusses the relationship dynamic and the role that the partner can play in the resolution or maintenance of vaginismus and implications for theory.

Finding Intimacy in the Absence of Penetrative Sex

The experience of attempting intercourse for couples for whom vaginismus is a concern is largely absent from the literature. In this study, couples and professionals described a pattern of endless unsuccessful attempts at intercourse that was quite often very painful, physically and psychologically, that was exacerbated with each attempt for both partners. For both the female and male partner, trying to have intercourse when the vaginal muscles are tight can lead to a lot of physical pain. However, the psychological pain could be much more difficult to deal with. The woman's experience of real or anticipated genital pain during the sexual encounter is well documented in the literature (Binik, 2010), but data on the emotional impact of endless attempts at failed or painful intercourse has not been investigated. Most of the women in this study blamed themselves for the vaginismus and the impact that they perceived that the vaginismus was having on their partners. Some of the women interviewed spoke about not feeling like a proper wife or partner because they couldn't have penetrative sex. They reported feeling guilty for preventing their partners from having a relationship that included sexual intercourse. The women frequently took all of the blame for the frustration and sadness that the vaginismus was causing in the relationship. The data revealed that vaginismus can also be emotionally traumatic for the partner. The male partner's experience of attempting intercourse with his partner when she is tensing and fearful has been largely absent from the literature. Although not prevalent in the data, some of the partners and therapists spoke about the trauma experienced by male partners who feel like they are responsible for potentially hurting their partner with each attempt at intercourse. Feelings of guilt and self-blame were reported, that they might be responsible for their partners' pain with each attempt at sexual intercourse.

Many of the couples found it difficult to communicate about sexual matters. Sometimes they found it difficult to communicate their own emotional needs to one another. With each failed attempt, and increases in physical pain, the psychological pain of frustration, guilt and blame also increased for both partners and, in some cases, led to avoidance. Many of the therapists spoke about their clients avoiding any discussion of their sexual difficulties. For some of the couples who could see no way to resolve the problem attempts at communication were often avoided because it tended to turn into arguments. Dias-Amaral and Marques-Pinto (2018) describe the avoidance of intimacy problem, avoidance of the discussion of the search for solutions and avoidance of sexual activity, the "the avoidance circle" (p. 792). It has been suggested that, if a partner interprets sex-avoidance as a lack of attraction, interest or commitment from his partner, his reaction is likely to either be to exert pressure or to withdraw (Meana, 2009). In most cases, partners did not take their partner's sex avoidance behaviours personally, mainly because these couples had found other ways to be intimate and sexual and did not have underlying relationship problems. For the minority of couples experiencing relationship problems, sex avoidance was part of a pattern of wider intimacy difficulties creating a perpetual avoidance circle. In fact, as discussed by many of the professional participants, it was often better that the couple stop painful attempts at intercourse before a cycle of pain and trauma was set up. In these cases, it is suggested that the couple is more likely to find other ways to enjoy sexual intimacy without fearing that any attempts at intimacy means progression towards painful intercourse.

The majority of couples in this study had found their own ways to be sexual with one another in the absence of penetrative sex. Many of the couples noted that they have a very good sex life and were able to be sexual in other ways. They spoke about having mutually satisfying sexual experiences to the point of orgasm. In many cases, these sexual experiences reduced the sexual frustration and loneliness and any worries about vaginismus being related to a lack of attraction. Some of the couples said that they felt that the perhaps had put even

more effort into being sexual in other ways and making time to be intimate to make up for the difficulties experienced because of the vaginismus. Some also said that this shared experience had increased intimacy in many areas of their relationship.

Couples do not always identify non-consummation as a difficulty if sexual alternatives are mutually satisfying (Drenth, 1988). Many couples with vaginismus have a wider non-coital sexual repertoire that can quite often be enough to keep both partners sexually satisfied (Sampson et al., 2008). The quality of the relationship and relationship satisfaction tends to be unaffected by the ability to have full intercourse whether due to male sexual dysfunction (Bodenmann et al., 2006), or female sexual dysfunction (Hawton & Catalan, 1990). Basson's (2011) model of the human sexual response suggests that emotional and cognitive aspects are as important as physical ones for arousal and desire. A woman's feelings for her partner plays a very significant role in female sexual desire (Basson, 2008b). The evidence from the couple interviews indicate that desire for one's partner was not a factor in the vaginismic response. In the majority of cases, the couples found each other desirable and understood that vaginismus did not relate to a lack of attraction or deeper relationship problems.

Prior to this study, the couple experience of vaginismus has been largely absent from the literature. The couple and professional interviews in this study have provided a unique insight into the intimate lives of couples for whom vaginismus is a concern. The findings suggests that, for the majority of couples in this study with experience of vaginismus, relationships tend to be strong and vaginismus was not indicative of deeper relationship problems. Most of the couples interviewed said that other forms of intimacy are unaffected by the absence of penetrative sex and that they shared a mutually satisfying sexual relationship. Some of the couples said that the shared experience of dealing with vaginismus in their relationship had brought them closer and deepened their intimacy.

The Role of the Partner in Maintaining or Resolving Vaginismus

A major limitation of studies of vaginismus that have been reported in the literature is that they typically do not include, or under report, the male partner and relationship data (Davis & Reissing, 2007; Heiman & Meston, 1997; Oniz et al., 2007). This study is the first of its kind to interview couples together and to include the partner perspective in the data. Many of the professional participants described the partner as responding to the woman's experience of vaginismus with patience, understanding, sensitivity, support, compliance and tolerance. The data from this study revealed that, in most cases, the male partner put the needs of his partner before his own and responded to the woman with kindness and patience. Some of the professionals said that this response was likely to maintain the difficulty because, by being endlessly tolerant of the situation, the partner does not provide opportunities in the relationship for the woman to confront and challenge the experience of vaginismus. However, other professionals disagreed saying that many partners, although supportive, did express their frustration. In the couple interviews, many of the partners did express frustration but said that the concern for the woman in dealing with the vaginismus experience superseded their needs. Many of the partners in this study saw their role as supporting the woman through the difficulty and their own needs as secondary to that.

In the literature, partners are typically portrayed as "good guys…a calm, patient, kind worthy person with good values who is caring, friendly, loyal and easy going" (Sampson et al., 2008, p. 52). However, when partner data is actually included a wide variety of personalities, relationship dynamics and coping styles are evident. For example, one study of partners of women with vaginismus found that their personality characteristics were no different from the control group or population norms (J.J.D.M. Van Lankveld et al., 1994). Some studies have suggested that the passive aspects of the partner personality contributes to the maintenance of vaginismus by colluding with their partner in the avoidance of sexual

experiences and by avoiding an active role in resolving sexual relationship problems (Barnes, 1986b; Sampson et al., 2008; Silverstein, 1989). Some theorists have further suggested that the male partners' reluctance to deal with non-consummation may be a conscious or unconscious strategy to hide their own sexual difficulties, e.g. erectile dysfunction, (S. Dogan & Dogan, 2008; V. Klein et al., 2015; Masters & Johnson, 1970) but other studies have not found this to be the case (Sampson et al., 2008; Tugrul & Kabakci, 1997; J.J.D.M. Van Lankveld et al., 1994). Although mentioned by some professional participants as being a concern, male sexual dysfunction was not evident for any of the couples interviewed. Other authors have suggested that women with vaginismus seek out partners who are sexually inexperienced (V. Klein et al., 2015; Sampson et al., 2008) but this was not supported by the findings in this study and many of the partners had had previous sexual relationships. Some authors have suggested that the partner colludes with the woman because both are avoiding experiences that would trigger underlying sexual anxieties (Sampson et al., 2008) and unleash repressed feelings that might threaten the relationship (Clulow & Fonagy, 2009). However, rather than avoiding sexual intimacy, the couples in the study had found fulfilling ways to be intimate with one another and all had actively tried to resolve the sexual difficulty within the relationship.

The portrayal of partners colluding and passively contributing to the problem was not found in the data in this study. As previously stated, the partners interviewed in this study articulated both their frustration with their experience of vaginismus and their willingness to play an active role in its resolution. However, most of them saw their role as supporting their partners progress rather than taking charge of it. One qualitative study of male partners found that the tendency toward being a good guy actually enhanced the amount of support given to their female partners and their commitment to resolving the vaginismus. Ducat and Zimmer-Gembeck (2010) correlated a woman's personal need fulfilment, wellbeing and development with three partner behaviours; the provision of love and affection, support and reliability.

According to Arriaga and Kumashiro (2019), the self-confidence of anxious individuals can increase when their partners provide them with encouragement, support their engagement with new challenges and celebrating their successes. Studies of couples coping with GPPPD have found that when partner responses are facilitative, characterised by affection and encouragement of adaptive coping, the woman experienced lower pain during intercourse, better sexual functioning and the couple experienced increased adaptive emotion regulation and greater sexual satisfaction (N.A. Rosen et al., 2012; N.O. Rosen et al., 2014). Therefore, rather than being an impediment, studies suggest that providing support and understanding is more likely to contribute towards the resolution of pain disorders including vaginismus.

However, it is also important to point out that this was not uniformly the case and a minority of partners had attempted to take control of the situation. In the case of two of the couples in this study (Isolde and Tristian and Medb and Alill), penetration was possible only when sex was for procreation and the male partners could prioritise their own sexual needs. These relationships were both at the point of breaking up at the time of interview. Studies of GPPPD have found that male partner responses characterised by expressions of hostility and frustration were related to greater subjective feelings of pain and lower sexual functioning for women (N.A. Rosen et al., 2012; N.O. Rosen et al., 2014). The authors of these studies suggested that partner responses, characterised by frustration and hostility, interfere with the woman's ability to adaptively regulate their pain-related emotions and reinforce the avoidance of pain and sex.

Masters and Johnson (1970) recommended that the partner should be involved in the aggressive management of vaginismus, but studies that have employed aggressive methods and penetration as an outcome of success has found that most women only had sex when they felt obliged or to conceive (Jeng et al., 2006; Ozdemir et al., 2008). In the cases where partners did attempt to take more aggressive control of the situation, there were often bigger relationship problems running concurrently and this response typically led to the vaginismus

worsening. Eva's partner Lir acknowledged that taking control over his partner's progression with dilators had been misguided and had nearly led to them breaking up. Ducat and Zimmer-Gembeck (2010) found that partner coercion in relationships was strongly linked to compromised well-being and reduced feelings of control. The need to feel in control was also identified as a dominant theme for women with vaginismus in this study and taking away that sense of control could elicit further feelings of threat and the need for defences. Katz and Myhr (2008) found that sexual coercion by male partners was negatively correlated with relationship satisfaction and sexual functioning.

In this study, needing a sense of control was identified as a dominant theme for those most at risk for vaginismus and a supportive relationship with a partner might allow for a relaxing of controls over behaviour. According to Sbarra and Hazan (2008), supportive relationships provide a sense of control over events previously perceived as uncontrollable. In the couple interviews, those that had resolved or were progressing with resolving their vaginismus spoke about the woman taking control of the sexual experience and the partner taking a more passive role. This was described as beneficial for both the woman and her partner. Having control in the sexual encounter creates an important psychological distinction for the woman between being subjected to penetration and consenting to it (Meana et al., 2015). The women in the couple interviews said that they felt safe because when in control of the sexual situation because nothing would happen without her consent. The men in the couple interviews said that they felt reassured that they would not be responsible for hurting their partners and that she was in any pain or discomfort, she would let him know. This mutual agreement and trust allowed for both the woman and her partner to be less fearful of the sexual encounter and to concentrate on its pleasurable aspects.

The findings of this study indicate that for couples for whom vaginismus is the only concern in their relationship, the partner's response is often to put the needs of his partner before his own, to support her and to allow her to decide the pace of resolution. This does not

mean that they are passive, attempting to hide their own sexual anxieties or dysfunctions, colluding with their partner, or that they do not feel frustrated. These partners see themselves as supporting the women through a very difficult time and this empathic response contributed to more successful relationships whether the vaginismus is resolved or not.

Resolving Vaginismus Within the Couple Relationship

The data from this study indicates that not all couples with sexual difficulties will need professional help to resolve the vaginismus. In this study, three of the couples had managed to resolve the vaginismus without professional advice or support. Many of the couples in this study had utilised a range of self-help strategies (e.g. buying books, going online, ordering dilators) before going for professional help. In the case of two out of the three couples dealing with secondary vaginismus, the self-help strategies combined with their previous experience of intercourse allowed them to resolve the difficulty without seeking professional help. In the case of the couples with primary vaginismus, the degree to which self-help strategies were useful varied and none had been able to utilise self-help strategies to actually resolve the difficulty. Many of the professional participants expressed concern about women and couples ordering products such as dilators online and using them without proper instruction or support. In their opinion, attempting to progress with a dilator programme in the absence of such supports had the potential to add further upset and pressure to an already traumatic situation. A recent study by Macey et al. (2015) found that women with vaginismus questioned the benefit of using dilators without adequate support or information because there was no space to explore wider issues around penetration difficulties.

Catania et al. (1990) identified that over 80% of American couples with sexual problems seek informal help and will try some form of self-help. According to J. van Lankveld (2009), self-help and self-reinforcement strategies have been an essential part of therapist-led sex-therapy because therapeutic change generally takes place in the privacy of

the client's home. A large randomised, controlled clinical trial of 199 couples with sexual dysfunctions in the Netherlands found an improvement in sexual problems, including vaginismus, when treated with ten weeks of cognitive-behavioural bibliotherapy (J.J.D.M. Van Lankveld et al., 2001). A study that compared bibliotherapy with limited therapist support to standard face-to-face group therapy as treatments for lifelong vaginismus found little difference between the group outcomes in terms of their ability to have successful intercourse (M.M. ter Kuile et al., 2007). However, studies that compare bibliotherapy with standard forms of face to face therapy are rare or absent from the literature (J. van Lankveld, 2009) making it difficult to draw firm conclusions about their short-term or long-term efficacy.

Although many of the couples in this study had utilised self-help strategies, they tended to be inadequate in resolving the difficulty for couples with primary vaginismus. In this study, only those couples who had the secondary type of vaginismus managed to successfully resolve the vaginismus without the support of professionals. In addition to the knowledge gained from self-help strategies the couples who had successfully resolved their vaginismus also had personal prior experience of sexual intercourse to draw from. A lack of support in how to apply the principles of self-help strategies to the specific problem has been identified a barrier to successful self-help for sexual dysfunctions (J. van Lankveld, 2009). Over half of the women in the couple interviews had attempted to use dilators and had managed to insert them but were unable to progress to intercourse. The three couples in this study with the secondary type of vaginismus, therefore, may have been better able to apply the self-help principles to their sexual difficulty because of their superior practical knowledge of how to have penetrative sexual intercourse.

Many of the couples had implemented some version of sensate focus, however, these techniques tended to be more successful for couples with prior experience of intercourse. According to Linschoten et al. (2016), information on the implementation of Masters and

Johnson's (1970) sensate focus programme and recent advances in sensate focus techniques tends not to be disseminated outside of workshops and training programmes for mental health professionals making it difficult to implement without a skilled therapist. Further, the process of sensate focus may have an emotional impact for couples that may be difficult to manage without a supportive therapist (Bancroft et al., 2003; Pacey, 2018). Some of the professional and couple participants spoke about the difficulties of moving from intimate touching to attempting intercourse without support and instruction on how to make that transition. As already discussed, most couples experiencing vaginismus will find other ways to be sexual and so often general sexual intimacy is not the problem, rather it is a lack of knowledge of how to make the transition to penetrative sexual intercourse without the benefit of prior knowledge or instruction. The data from this study suggests that, for many couples with primary vaginismus, support may be needed to progress towards intercourse.

The Role of Intimate Relationships in Fulfilling Previously Unmet Emotional Needs

> It is the connection between them and it is the love that holds them together (therapist Aengus)

As established earlier in the chapter, vaginismus is conceptualised here as a necessary adaptive survival strategy for growing up in a household characterised by attachment difficulties, perceived emotional misattunement and sexual repression. The data also suggests that a strong supportive couple relationship may have the potential to heal previously unmet emotional and safety needs. Many of the couples spoke about the solidarity and safety that they felt in the relationship having gone through a significant difficulty, facing it together, and committing to one another and the relationship whatever the outcome. In many cases, the couples were able to reframe vaginismus from a sexual problem to a shared experience that had strengthened the relationship because they had faced it together. The majority of professionals stated that, in most cases, vaginismus is a couple problem rather than a

relationship problem and couples who experience vaginismus tend to have a very sound supportive relationship. In their experience, many couples have a strong emotional connection and feelings of fulfilment come from many aspects of the relationship. The sexual aspect, although important, is recognised as being one aspect of the relationship rather than the one that defines it.

If a good enough relationship was not provided by the family of origin, the couple may provide a secure base and good enough closeness for each other in their relationship (Orbach, 2009). Although early attachment theorists have suggested that insecure patterns of attachment with parents are repeated in couple relationships, e.g. (Hazan & Shaver, 1987), later researchers found that changes in social support could change subsequent attachment styles over time (Sroufe, 2005). According to Crittenden's (2006) dynamic-maturational model of attachment, patterns of attachment are self-protective strategies that change when individuals feel that it is safe to behave in other ways. Sbarra and Hazan (2008) suggest that dysregulated attachment systems can be re-regulated through the conditioning of biological reward systems within the adult pair bond and the emergence of feelings of safety and security. In adult relationships, intimacy, including sexual intimacy, can activate the physiological rewards systems of the brain, facilitating the experience of pleasure and reducing stress. The authors suggest that repeated pleasurable experiences, stress alleviation and feelings of security associated with the partner leads to a strong attachment bond. When sexuality is dysfunctional, attachment can maintain the relationship (Crittenden, 2006). An fMRI study by Coan et al. (2006) showed that just holding the hand of one's partner can neutralise the threat response.

It has been proposed that the attachment security of the individual in a couple relationship depends on the attachment security of both partners that interact in complex and reciprocal ways (Mikulincer et al., 2002). According to Arriaga and Kumashiro (2019) long-term attachment security is enhanced by the partners' abilities to mitigate insecurity in the

short term and to construct secure working models in the long term. The authors suggest that over time attachment anxiety can be replaced by interdependence and trust when partners provide each other with reassurance, affection, safety and commitment. In the majority of the couple interviews in this study, the relationship they described was characterised by feelings of security, trust and commitment. Many of the couples said that they had faced a significant challenge together and regardless of the outcome appeared to maintain a loving committed relationship that had been strengthened by this shared experience. Thus, a strong supportive relationship can transform an insecure, fearful attachment style into a secure one. The supportive couple relationship "…is not a return home since this home had never before existed. It is the discovery of home," (A. Miller, 1979, pp. 53-54).

For the majority of couples with vaginismus in this study, the relationship was a significant motivator to begin to work on not only the vaginismic response, but the wider issues that contribute, such as previously unmet emotional needs and attachment insecurity. A secure relationship can regulate the emotional systems reducing the feelings of threat and increasing feelings of safety. When a woman feels protected, there may be less perceived need for her to disconnect from herself and her body, from her emotional and sexual feelings and from intimate relationships. Therefore, a secure relationship with a trusted partner can facilitate these connections by meeting her emotional needs.

Implications for Theory

According to Ng (2010), in order to understand vaginismus, it is necessary to examine it from three different three perspectives; intrapersonal, interpersonal and cultural, and the interpersonal level is the one that is the least explored As previously mentioned, a major limitation of studies of vaginismus that have been reported in the literature thus far is that they typically do not include or under report partner and relationship data (Davis & Reissing, 2007; Heiman & Meston, 1997; Oniz et al., 2007). This study is the first known study to

interview couples together about their experiences of vaginismus and to include partner data in its findings and provides important data to fill this gap in the literature on vaginismus. When partner data is included, the theoretical understanding of vaginismus is expanded from a female sexual dysfunction to a sexual difficulty within a couple relationship.

The experience for couples attempting to make a sexual connection in their relationship while experiencing vaginismus has not previously been available in the literature. This study has elucidated the traumatic experience of couples who have experienced endless attempts at painful and impossible sex and the frustration of not being able to communicate these difficulties, even to one another. It further describes the resourcefulness of couples that have found their own way to be sexual and to define their sexual relationship on their own terms, in the absence of penetrative sex. This study also challenges the dominant stereotype of the male partner in the literature as maintaining the difficulty by being passive, avoidant and collusive in his approach to the problem. Rather than maintaining the difficulty, the data from this study suggests that the gentle, patient, understanding support provided by the partner reduces the woman's feelings of threat and contributes towards the decision to resolve the difficulty together as a couple. Further, this study has demonstrated that the secure attachment provided by the couple relationship can contribute to the healing of the trauma of perceived unmet needs in previous relationships. A sound supportive relationship may reduce feelings of threat and can facilitate connection to the self and the body, to emotional and sexual feelings, and a relationship with an intimate partner.

The couple relationship can be an opportunity to challenge entrenched beliefs about the trustworthiness of others and the threatening nature of sexual relationships by providing a different experience of relationships that meet emotional needs and offer feelings of safety. Conversely, a relationship that replicates the negative experiences of early relationships can confirm negative beliefs about relationships and exacerbate anxiety and feelings of threat. This study is the first of its kind to document the experience of couples who are trying to

make a sexual connection and to progress towards sexual intimacy while also dealing with the problem of vaginismus within the relationship.

The Experience of Seeking Help for Vaginismus in the Irish Context

As discussed in the previous section, the couple relationship can be an opportunity to confront and overcome vaginismus. When seeking sexual connection within the relationship and experiencing painful and frustrating attempts at sexual intercourse, couples may decide to reach out for help to professionals. This study documents a wide range of experiences of help seeking from many different types of professionals who work with women and couples experiencing vaginismus. A dominant theme was that accessing accurate information about vaginismus was hit and miss with wide variations in professionals' awareness and knowledge of vaginismus and in the availability and accessibility of services. This section discusses the help seeking experiences of Irish women and couples experiencing vaginismus and the services accessed that were perceived as unhelpful and helpful.

The difficulties the couple experiences can be compounded when experiences of seeking support from professionals are confusing and upsetting. This first section looks at the experiences perceived as negative by Irish women and couples seeking the help of professionals to resolve their vaginismus. It describes the barriers to treatment including the training of healthcare professionals, systems of referral, difficulties with access and an overall lack of awareness about vaginismus.

Attempts at Breaking Down the Physical Barrier will Increase the Vaginismic Response

> If you try to beat a defence down, then it only gets stronger
>
> (Medical Doctor Fand)

For many women and couples, the first professional they will approach for help with vaginismus will most likely be a family doctor. A common experience discussed by

participants was an impossible, difficult or painful attempt at taking a smear test in a primary care setting. In some cases, it was in the context of a routine smear test and for others it was in the context of an internal examination in order to confirm a diagnosis of vaginismus. In this study, the majority of the professionals but only a minority of the women interviewed thought that the internal examination was important to make an accurate diagnosis, to rule out physical conditions, and to address fears. According to some of the professionals, the internal exam could provide a way to open the conversation about vaginismus with their patients, but according to some of the other professionals and the majority of the couples interviewed, in actuality this conversation rarely takes place in primary care settings. Some of the professionals interviewed stated that the insistence on a physical examination was more likely to reinforce the idea that vaginismus is a physical difficulty to be resolved medically. They also said that, in their opinion, there is little support for the idea that vaginismus needs to be confirmed in this way, stating that the women's experience should be sufficient confirmation. The pelvic examination is still routinely used to confirm a diagnosis of vaginismus but is often impossible because of the anxiety it provokes (Binik et al., 1999; Reissing et al., 2014). There is also little evidence that the ability to undergo an internal examination can be any indication of the ability to engage in sexual intercourse (Parameshwawran & Chandra, 2019; Reissing et al., 2004). Recently, the American Medical Association concluded that the harm caused by routine pelvic examinations far outweighed any potential benefits for women and recommended that they be discontinued (Morgan et al., 2015).

According to the professional participants, because of the emphasis on the medical model in their training, not only are family doctors more likely to perceive vaginismus in purely physical terms, but also to refer women on to obstetric and gynaecological services rather than therapeutic ones. This can further confirm the idea that their genital area is abnormal and that vaginismus is a physical problem to be resolved medically. Many of the professional participants spoke about women being referred by their family doctor to obstetric

and gynaecological consultants for further physical investigations. Three of the women in the couple interviews had been sent to consultant gynaecologists and two had undergone stretching under anaesthetic, an experience that was both painful and traumatising. According to Khan-Singh (2019) if carried out correctly, an internal examination can be a therapeutic opportunity to open up the conversation around the fear of penetration. However, in many instances, this therapeutic opportunity does not take place and the experience is perceived as traumatic. For example, a survey of five hundred women about their experiences of obstetric and gynaecological experiences by Menage and Counselling (1993) revealed that over 20% of the women said that their experiences were distressing and terrifying and thirty of these experiences would meet the DSM criteria for post-traumatic stress disorder. None of the women in the couple interviews had had positive experiences of being referred to gynaecological services and said that, if anything, the vaginismic response had increased afterwards.

Some of the women in the couple interviews spoke about having to find and attend many different types of professionals before they found someone who was qualified to treat vaginismus. Some of professional participants spoke about the experience of their clients who had attended previous therapists who had adhered to the behavioural model in their approach to treatment. In their experience, some of the women had been offered little from the sessions beyond being advised to attempt penetration with fingers or dilators. Many of the professional participants expressed concern about the inadequate qualifications and training of those offering their services as psychosexual counsellors in Ireland. Many studies have commented on the artificial divide between sex and couple therapists as detrimental to couples seeking help for sexual and intimacy difficulties (McCarthy & Thestrup, 2008; Pacey, 2018; Timm, 2009). A recent systematic review and meta-analysis of medical and psychosocial interventions for vaginismus by Maseroli et al. (2018) concluded that there was little evidence to suggest that behavioural based sex therapies were superior to other forms of therapies and

cautioned that the success of any intervention for vaginismus is questionable if the successful outcome measure is vaginal penetration rather than sexual satisfaction. In hindsight, all of couples in this study recognised that without dealing with the psychological aspect of vaginismus, the purely physical therapies that they had paid for had very little hope of success. The couples also suggested that a multidisciplinary approach to the treatment of vaginismus would benefit women and couples by offering a holistic approach to treatment that took into account the multifaceted nature of vaginismus. Many studies have suggested that, given the complex and multifaceted nature of vaginismus, a multidisciplinary approach may be superior (Anastasiadis et al., 2002; Barnes, 1986b; R.C. Rosen & Leiblum, 1995) and could be used to maximise and optimise treatment options (Fajewonyomi et al., 2007; Meana, 2009; Tulla et al., 2006; Valins, 1988).

In summary, negative experiences with internal examinations and behavioural-based treatments have the potential to reinforce the vaginismic spasm physically and psychologically by producing a real threat of penetration while also reinforcing the idea of the genital area as abnormal and the spasm as a physical problem to be medically treated. The theory presented here explains the vaginismic response is an adaptive response to threat, and attempts to break down the physical barrier without dealing with the underlying fears may make the response stronger. The women interviewed in this study said that when resolving the physical aspect of the problem was the focus of treatment, the experience was often traumatic and the vaginismic response often increased in response to the perceived physical and emotional threat. The complex nature of vaginismus needs to be considered when designing treatment options for women and a multidisciplinary approach that takes account of all aspects of vaginismus, physical and psychological, might be more beneficial for women and couples.

Family Doctors Need to Open up the Conversation about Sexual Wellbeing with Patients

The professional and couple participants in this study often spoke about either an complete absence of information from family doctors about vaginismus or a perceived dismissive attitude that trivialised the problem. The experiences of the women in this study was that they frequently left the doctor's surgery with no information on vaginismus or how to resolve it and believing that their sexual difficulty was rare and unusual. The most common advice from family doctors about vaginismus in the participants' experience was to go home and just relax and have a glass of wine. The perceived lack of compassion by the family doctors was mentioned by some of the women as among the most difficult experiences they had to deal with. Studies in Ireland and Britain concluded that the low priority afforded to sexual difficulties in primary care settings was related to a lack of time allocated to family doctor appointments (Byrne et al., 2010; Cromme et al., 2016; Humphrey & Nazareth, 2001; Morgan et al., 2015). The medical professionals interviewed for this study similarly highlighted the difficulties of trying to deal with something as complex as a sexual difficulty in the time allocated to appointments and a lack of time to follow up with patients. The couples spoke about the difficulties of seeing a different family doctor every time they made an appointment and having to repeat their very difficult experiences of vaginismus in a time pressured environment to family doctors who were not knowledgeable about the condition and did not offer any advice. Some of the women also spoke about being made to feel that they were wasting their doctor's time. A recent community-based qualitative study by Cromme et al. (2016) found that when time constraints were salient and the family doctor adopted a dismissive interactive style, there was an increase in patients' fears of unnecessary help-seeking. The patients said that when symptoms were not persistent, worsening, or life-threatening, they were made to feel unworthy of attention from their family doctor. A survey of women with vaginismus who had attended primary care services in Britain by Ogden and

Ward (1995) study found that adverse experiences in primary healthcare were negatively related to further help seeking attempts.

Many of the professional and couple participants thought that it would be very helpful if family doctors had enough knowledge to ask some routine questions about vaginismus to be able to have a conversation with the woman and to refer her to appropriate services. However, in the majority of cases, the participants said that this conversation very rarely took place or was shut down by the medical professional who was perceived as dismissive or unknowledgeable about the condition or both. In their experience, family doctors did not ask routine questions about sexual health or specific questions about their sexual difficulty. The number of patients who will disclose sexual difficulties has been found to substantially increase when doctors ask questions directly as compared with rates of spontaneous disclosure (J. van Lankveld, 2009) but international studies indicate that the opening of conversations by family doctors would be uncommon. Women surveyed in an Iranian study of women seeking help for sexual problems complained that they were not asked routinely about sexual health during doctor's visits and the study concluded that family doctors do not feel qualified to treat sexual dysfunctions (Vahdaninia et al., 2009). Surveys of family doctors in Ireland and the UK revealed that barriers in opening the conversation about sexual dysfunction with their patients included a lack of awareness, confidence, training and knowledge (Byrne et al., 2010; Humphrey & Nazareth, 2001).

It is important to train healthcare professionals in asking routine questions in order to open up the conversation with their clients about sexual matters. An Irish national survey by Byrne et al. (2010) found that 70% of family doctors rarely or never discussed sexual problems with patients with coronary heart disease, despite the fact that sexual problems were very common in this population. The family doctors stated that a lack of awareness, confidence, training and knowledge were barriers to having a discussion about sexual problems in their practice. The Cardiac Health and Assessment of Relationship Management

and Sexuality (CHARMS) study in Ireland found that family doctors were uncomfortable initiating a conversation about sexual dysfunction following cardiac surgery and left it to their patients to raise the issue (D'Eath et al., 2013). Female sexual difficulties were less recognised and were considered by family doctors as being more difficult to treat because they "stem from emotional issues rather that the more easily treated physical…problems" (p. 11). The authors concluded that there was a significant discrepancy between the adequacy of support health care professionals thought they were providing and the perception of their patients. Cultural and personal barriers may inhibit the ability of healthcare professionals to talk about sex but these skills can be taught using training methods such as the use the PLISSIT (permission, limited information, specific suggestions, intensive therapy) models (Taylor & Davis, 2006; Timm, 2009). Health care professionals could also be trained in the use of standardised questionnaires of female sexual dysfunction as part of their routine appointments with women (Clegg et al., 2012). Family doctors are often the first port of call and the gatekeepers to further help but the survey by Ogden and Ward (1995) highlighted that negative first experiences were likely to impact on women's' decisions to seek help for vaginismus in the future. The authors concluded that is important that healthcare professionals give women and couples the opportunity to discuss their sexual difficulties by opening up the conversation and providing a supportive environment.

Lack of Accurate Information about Vaginismus Prevents Help Seeking

Many of the professional and couple participants spoke about the experienced lack of awareness and false perceptions about vaginismus in Irish society as a hindrance to help-seeking. The Irish culture of secrecy and shame surrounding sexual matters, discussed in earlier sections, can contribute to a deep sense of shame and a reluctance to discuss vaginismus and this can have an impact on the ability to disclose it to anyone, including healthcare professionals. One of the sources of shame reported by the participants was the

perceived association between vaginismus and sexual abuse. Although none of the women interviewed had been sexually abused and the professionals interviewed confirmed that sexual abuse was a concern in only a minority of cases of vaginismus, many of the participants said that, in their experience, this perception was often held by medical professionals. They further speculated that this could be another reason why doctors were reluctant to discuss vaginismus with their patients. Few studies have demonstrated the link between vaginismus and sexual trauma (de Jong et al., 2009; J.D.M. van Lankveld et al., 2010). Despite this, there is evidence that women have been discouraged from seeking help for vaginismus by a belief that such counselling would lead to the discovery of repressed childhood events (Ogden & Ward, 1995).

When the couple participants did attempt to discuss the vaginismus with family doctors, they experienced a lack of awareness and information, the idea of vaginismus being uncommon and relative unique to them was reinforced and added to the sense of shame. They said that the provision of fact-based leaflets in the primary care setting as well as greater awareness in the media would be very helpful. The CHARMS study found that Irish patients welcomed the provision of leaflets about sexual dysfunction in primary care settings that would provide a general understanding of the issues and information about accessing services (D'Eath et al., 2013). The family doctors surveyed, however, were not in favour of the provision of leaflets, preferring online resources. The patients surveyed said that they had less confidence in the quality of information available from online resources and found that the information was too general to be useful. Ozdemir et al. (2008) found that early help seeking for vaginismus was related to increased access to information via the media and on the internet. However, the majority of participants in this study reported that searching for accurate information was 'hit-and-miss.' Many reported that there was a lack of information about the psychological component of vaginismus, with many websites focusing on medically based behavioural approaches and that some had reinforced the perceived association between

sexual abuse and vaginismus. The couples in this study similarly said that the quality and accuracy of the information they had accessed online varied and was often too general to apply to their particular context. The couples spoke about the lack of awareness among family doctors and online as contributing to the psychological burden of vaginismus.

The couples in this study recognised that there was a discrepancy between the medical understanding and approach to vaginismus by family doctors when they themselves understood that the difficulty had both a physical and psychological component. The couples thought it would be very helpful for people experiencing vaginismus if family doctors had some basic training in psychosexual matters or could provide referral information. Ogden and Ward (1995) found that almost 70% of the women rated family doctors responses as unhelpful and their dissatisfaction reflected an incongruence of beliefs between women experiencing vaginismus and those of healthcare professionals, and the clash of medical and psychosocial understandings of the possible causes and treatments of vaginismus. Some of the women surveyed mentioned painful examinations, a mechanistic approach to vaginismus, an absence of discussion, and comments about their mental health to be inappropriate. Alternatively, family doctors were rated as helpful when a diagnosis and information about vaginismus was given, when the woman was provided with emotional support, problem solving and communication strategies, and the family doctor had made an attempt at normalising their experience. Ward and Ogden also recommended that family doctors, as the first point of contact for women experiencing vaginismus, could be trained to evaluate the expectations of their patient in order to reduce the discrepancies between the beliefs of the family doctor and the patient and to recommend appropriate professional intervention for their individual needs.

Despite the insistence by some gynaecologists that only they are equipped to diagnose vaginismus and this can only be done by physical examination, e.g. (Graziottin, 2009), vaginismus is rarely discussed at medical meetings and does not feature in medical training or

residency programs (Pacik, 2014b). The Summit on Medical School Education in Sexual Health in 2013 concluded that the sexual health training of doctors in North America was inconsistent and, in some cases, reduced (Coleman et al., 2013). The authors recommended that, to be effective, the teaching of sexual health needs to be integrated throughout medical training within a multidisciplinary framework that encourages cross-sector cooperation for integrated care. The CHARMS study in Ireland identified that family doctors had no training in the area of sexual dysfunction (D'Eath et al., 2013). There is recent evidence, however, that the need for undergraduate training for doctors in discussing sexual dysfunction with their patients is now being recognised in Ireland. The latest version of the curriculum for the Irish College of General Practitioners includes, as part of the module on sexual health, a learning outcome that specifies doctors should be able to "understand sexual dysfunction as a common issue and have the ability to discuss this with patients" (ICGP, 2020, p. 164). Such training has been shown to have long term benefits as a recent survey in the UK revealed that the amount and quality of training provided for doctors at undergraduate level contributed to more confidence and proactiveness in diagnosing and managing sexual issues ten years later (Clegg et al., 2016).

Lack of Trained Professionals and Public Clinics are Barriers to Resolution

Many of the couple participants in this study stated that they did not receive adequate information about vaginismus or appropriate referrals and had to do the research themselves. Often, this was the start of a very difficult journey, especially for women and couples south of the Irish border where systems of referral are not established and there are no dedicated psychosexual clinics. The CHARMS study in Ireland identified that family doctors generally did not refer patients with sexual dysfunction on to other services because either there was nowhere to refer them or because waiting lists were too long (D'Eath et al., 2013). In Ireland, there is a stark North-South divide in terms of service provision for psychosexual problems.

Service provision north of the border includes free dedicated psychosexual clinics to which referrals can be made to psychosexual counsellors and multidisciplinary teams. All of the couples interviewed lived south of the border, and many discussed having to source psychosexual counsellors on the internet and to pay privately for their services. For many of the couples, it was necessary to attend many different types of professionals before they found services that were helpful and they rated these experiences as being a waste of time and money. The women also had no way of knowing if the professional they were attending were actually qualified to work in the area. They also mentioned the lack of trained psychosexual therapists and restricted appointment times as a barrier to accessing services. In 1986, an Irish study reported that there was a lower provision of local services for vaginismus in rural areas (Barnes, 1986b). Forty years on, the participants in this study still reported that there were very few services available outside of the capital and it was often necessary to travel to Dublin. According to the majority of the couples, the cost of the services available for vaginismus places a heavy financial burden on already distressed couples.

Implications for Service Provision

Family doctors are often the first port of call for women and couples attempting to seek help for vaginismus. The medical focus on diagnosis of vaginismus by internal examination and resolution of the vaginal spasm can strengthen the sense of threat and exacerbate the vaginismic response. The lack of awareness, inaccurate information, limited appointment times and a perceived absence of compassion regarding vaginismus from family doctors may deter women and couples from future help seeking attempts. Family doctor responses can add further distress to a couple who are often unnecessarily burdened by shame because they are made to feel that their sexual difficulty is relatively uncommon, dismissed as trivial or associated with sexual abuse. There is a need for family doctor training in the area of sexual dysfunction that broadens their understanding further than the medical model provides.

Family doctors could be made aware of the implications for their patients of confirming vaginismus through internal examinations or referrals to obstetric and gynaecological services. There needs to be an awareness of the range of services to which they can refer their patients. Family doctors should be trained in use of routine questions to open up conversations about sexual health and wellbeing with their patients.

The couple interviews revealed that the lack of training for family doctors and awareness of vaginismus places the burden on women and couples to spend a lot of time and money on finding help. The couples stated that they should be provided with support, especially from those in primary healthcare settings not have to waste time and money in finding accurate information and help when they are already experiencing distress. The data revealed that there is a need for the training of medical professionals and psychosexual counsellors in Ireland with regard to sexual dysfunctions. Many of the professional and couple participants expressed their concern about inadequately trained professionals who should not be working in the field. Training for therapists could include more than behaviourally-based approaches and a one-size-fits-all approach to treatment. In the Republic of Ireland, there is a need for a system of referral to which family doctors can refer their patients. Dedicated psychosexual clinics with specialised multidisciplinary teams are recommended. Multidisciplinary options may provide holistic individualised approaches for women and couples with complex sexual difficulties. However, it is important that these services are localised outside of the capital in order to provide services to rural areas.

Not all of the experiences of help-seeking were negative, however. Some of the couples in this study had been successful in finding the help that they needed to work towards resolving the vaginismus and the next section explores these positive help-seeking experiences.

The Therapeutic Relationship can Help with Understanding and Overcoming Vaginismus

Despite the very difficult experiences of couples seeking help for vaginismus discussed in the previous section, for couples who managed to access appropriate therapeutic supports, the therapeutic relationship was experienced as a catalyst for the couple to connect and provided the support for them to resolve the vaginismus. Most of the therapists interviewed suggested a structured sensate focused approach to resolving the vaginismus. As discussed in the previous section on the couple experience, the couples that had resolved the vaginismus in their relationship had used their own version of sensate-type techniques but these couples had been dealing with secondary vaginismus and had prior experience of successful and pain-free sexual intercourse. For those couples experiencing primary vaginismus, difficulties in resolving the vaginismus without support was compounded by their lack of previously successful experiences and the emotional and physical challenges of engaging with sexual intercourse for the first time in their relationship. A very important aspect of engaging with therapy for many of the couples was the provision of a structured plan to resolve the vaginismus supported by a relationship with an understanding and knowledgeable therapist.

Connecting with professionals with appropriate training and a broad understanding of the biopsychosocial origins of vaginismus can help women and couples broaden their understanding of vaginismus from a purely physical problem to one with an important psychological component. Many of the couples in this study said that this realization was an important turning point in their ability to understand vaginismus and to engage with support services. Whether they had resolved the vaginismus or not at the time of interview, all of the couples understood vaginismus to be psychological in origin and expressed their frustration with the medical emphasis in the treatment options suggested by family doctors and online. A survey in Britain found that the dissatisfaction experienced by women seeking help for vaginismus arose from the discrepancy between their own psychosocial understandings of the

possible causes of vaginismus and the purely medical understanding of family doctors (Ogden & Ward, 1995). According to the participants, one of the most important insights a psychosexual therapist can offer is a normalisation of vaginismus as a common experience for couples that can be treated. This helps to reduce the shame, guilt and blame that couples may be experiencing and to reframe vaginismus as a problem that they can resolve together. Incorporating a biopsychosocial approach when working with individuals or couples can be beneficial in helping couples to understand vaginismus and approaches to treatment.

The findings of this study also place an importance on the involvement and contribution of the male partner in supporting the therapeutic process. Meana (2009) has identified the shift in the couples' perception of vaginismus from the woman's problem to a couple problem as a crucial first therapeutic intervention. According to R.C. Rosen and Leiblum (1995), the involvement of the partner is crucial in sex therapy. In treating sexual problems, the focus on the relationship is now considered to be essential (Johnson & Zuccarini, 2010). Some of the partners in this study did not, at first, understand how they could be involved but were very supportive once they were included. Although sexual difficulties may be rooted in early attachment styles, couple therapy focuses on the attachment that is co-created by the couple to form a secure base and good enough closeness in the relationship (Orbach, 2009). Five of the male partners in this study said that being involved in the therapy helped them to understand what their partner was going through and to clarify their role in providing practical and emotional support. Involving the partner affords an opportunity for the partner to understand vaginismus and to receive guidance on providing positive feedback and emotional support to his partner (Bergeron & Lord, 2003). A recent study of couples with sexual difficulties because of vulvodynia by Bois et al. (2016) found that interventions designed to increase empathic responses and disclosure in the couple relationship alleviated sexual distress and sexual dissatisfaction.

For the couples in this study, the provision of a structured supportive programme that gradually moves the couple towards greater sexual and emotional intimacy was helpful in providing the framework they need to begin to resolve their vaginismus. In the experience of the couples who felt that they had made progress, the inclusion of psychological therapies in conjunction with attempts to reduce the vaginismic response were experienced as superior than purely behaviourally-based ones. As discussed in an earlier section, for many of the women in this study, attitudes towards sex were perceived as negative and sex education as inadequate at school and at home. At the beginning of therapy, therapists can help to offset these negative experiences by providing basic fact-based information about anatomy and sex (Zielinski, 2013) and by modelling a sex positive attitude toward sex by challenging entrenched negative attitudes (Ng, 2001). The provision of a structured progressive programme such as sensate focus with the support of a therapist gives the couple time to experience sensuality and pleasure and to make a sexual connection without the pressure of intercourse (Masters & Johnson, 1970). Many of the professional and couple participants spoke about the psychological benefit of the sex ban aspect of sensate focus. For many of the couples, although they could not have sex, the symbolic banning of sexual intercourse took the pressure off the expectation of intercourse and provided boundaries that allowed them to be more relaxed in the sexual encounter. Banning intercourse has been found to significantly reduce stress and to allow couples to more successfully engage with other aspects of treatment (Meana et al., 2015).

While behavioural approaches have been criticised in the literature, participants in this study noted that these techniques can be useful when incorporated as part of an integrative therapeutic approach, as they can help to provide an emotional connection through increasing desire and arousal as well as communication of sexual experiences and desires. In a study by Pacey (2018) psychodynamic therapists used sensate focus to modify early mental models of relationships through tactile experiences. Sensate focus exercises acted as the catalyst for the

emergence of a range of anxieties that re-enact preverbal bodily experiences that be experienced as catastrophic for the couple, and may provide barriers for non-engagement. Meana (2009) states that anxieties that may emerge from sensate focus include fears of abandonment, fears of intimacy and feelings of inadequacy and the therapist will need to help the couple through these anxieties. For the couples in this study, sensate focus had a number of beneficial outcomes. Two of the couples said that working on their intimacy increased their felt sense of connection to one another and reduced the sense of loneliness they were feeling. For four of the couples, working together on intimacy had reduced the male partner's concerns about hurting his partner because she would be the one taking control of the situation. She could trust him to stop when she needed him to and to provide encouragement and support. The agreement increased the trust and security within the relationship and allowed both partners to take greater ownership of sexual pleasure for each other and for themselves. Feelings of safety and emotional connection with one's partner provides a scaffolding for the development of caregiving and sexually intimate relationships (Johnson & Zuccarini, 2010). Repeated pleasurable experiences between couples, including sexual intimacy, has been shown to strengthen the association between feelings of safety and security and one's partner (Sbarra & Hazan, 2008). According to the participants in this study, sensate focus exercises provided a structured framework and time to support them to connect sexually, and a safe space to build trust and to connect emotionally. When both partners feel safe to connect in the sexual encounter, the need for protective disconnection and the vaginismic response gradually decreases allowing for a sexual and emotional connection to form. Sensate focus can provide a structured pathway to gradually increase feelings of safety and the intimate connection between partners.

It is important to note that the therapy often takes place within the same cultural context in which the difficulties arose, and so it is incumbent on therapists to be aware of how these cultural influences might impact on their approach to sexual difficulties. Cultural competence

is defined as "the capacity for the therapist to be self-aware in regard to her or his own identities and cultural norms…that allows for creative responses to the ways in which the strengths and resiliences inherent in identities inform, transform, and are also distorted by distress and dysfunction" (L.S. Brown, 2009, pp. 341-342). In the couple interviews, some insensitive comments by previous therapists, that may have been influenced by their own predominantly Catholic upbringing, were reported. For example, two of the women (Niamh and Isolde) mentioned that their therapist had made judgemental comments about them not fulfilling their husband's needs. Therapists may feel deeply uncomfortable discussing issues around sexuality because of their own familial upbringing that may have been rooted in particular cultural or religious messages (Timm, 2009). It is important that psychotherapists understand and reflect upon their own cultural biases when working with clients (L.S. Brown, 2009). Borg et al. (2010b) recommends that, particularly in the case of vaginismus, it is important that professionals be able to discuss issues around sexually restrictive morals and to explore alternative perspectives with clients.

Healing Unmet Emotional Needs through Therapeutic Relationships

Many of the couples in this study spoke about needing a connection with their therapist to progress. The perceived lack of connection with their therapist had led to some of the women and couples dropping out of therapy. The development of a bond between the therapist and client takes time especially if there is an insecure attachment to begin with (J.R. Schore & Schore, 2008). Because vaginismus can be associated with a disturbed attachment to parents, the therapist often takes the role of the parent in the therapeutic relationship (Valins, 1988), giving the client the "permission" and confidence to try new behaviours and to remove negative attitudes towards sex (Ng, 2001, p. 47). According to A. Miller (1979) therapy can elucidate and help the woman to confront difficult dynamics in the family of origin, making it possible to empathise with herself as a lonely child with previously unmet

needs and to connect authentically, and possibly for the first time, with her own needs and feelings. Miller further states that there may also be a need to relinquish expectations of the mother ever changing or gaining an awareness of the her role in the difficulties experienced by her daughter. The ability to reflect upon and to discuss painful or traumatic past experiences in therapeutic settings have been shown to be protective factors that provide the foundation for secure attachment (Holmes, 2000). Experiencing early unmet needs as less threatening and reaching out to others can reduce physiological reactivity and establish a sense of felt security (Sbarra & Hazan, 2008). According to the participants in this study, the therapeutic setting provided a safe space to allow them to explore the meaning of the vaginismus in the context of their interpersonal relationships and to take ownership of their sexual selves and relationships.

According to the couple participants, therapy was most successful when they felt that they had a connection with their therapist who provided support throughout the process of resolving the vaginismus, including encouragement during both their successes and setbacks. Successful therapy requires the commitment and emotional involvement of the therapist (Tutte, 2004). Intensive therapeutic relationships have been shown to restructure right hemisphere dominated dysregulation to create a self-regulatory system that is more resilient and capable of dealing with stress and building secure interpersonal relationships (J.R. Schore & Schore, 2008). These authors suggest that a regulation theory of therapy to enable therapists to deal with the difficult experiences of their clients' unmet emotional needs in childhood. They suggest that an attachment-based therapeutic relationship that concentrates on unconscious, nonverbal and affective factors, rather than conscious, verbal, cognitive ones, can facilitate a more profound process of change in psychotherapy, and can play a role in the regulation of previously dysregulated affective states. It has been suggested that both the mother-infant bond and the doctor-patient relationship involves the caregiver being attuned to the experience of the other and leads to interactive emotional and physiological response

(Adler, 2002). DiMascio et al. (1957) called the attunement of psychophysiological patterns between the therapist and the patient, “physiological identification” and concluded that it was an essential component in therapeutic rapport and empathy (Levenson & Ruef, 1992). Many of the women and couples in this study said that therapy had been successful because they had a connection with their therapist that was perceived as nurturing and supportive. They credited that encouragement and hope provided by their therapist as the key element of the therapy that helped them to progress towards resolving their vaginismus.

The therapeutic relationship can provide a nurturing healing experience for those with unresolved unmet emotional needs and can provide the safety and security to explore unresolved emotional pain and to regulate affective states. The therapist can model an empathic, nurturing, sex-positive parental role to give their clients permission, perhaps for the first time, to explore their sexuality. The therapist can also facilitate the sexual connection between the woman and her partner and to act as a support for any difficult emotional experience that may arise during this process.

Implications for Practice

The data reveals that the felt connection with a therapist who specialises in sexual and relationship therapy was of vital importance for couples who were attempting to resolve their vaginismus. The therapist can provide a number of supports for couples. For the couples in this study, the shift in understanding vaginismus as a purely physical problem to one with important psychological aspects was one of the most significant contributions to their understanding of vaginismus. Working with an appropriately trained psychosexual counsellor can help to bring about this new understanding. The therapist can also provide education and be a sex positive role model that helps the woman and couple challenge any negative messaging and shame regarding sexual behaviours that may have arisen from their particular cultural or familial background. The therapist can normalise the experience of vaginismus for

the couple by telling them how common the difficulty is and to reframe the experience from a woman's problem to a couple problem to be resolved together. The inclusion of the partner can benefit the progress of the therapy and provide emotional and practical support for the woman. The therapist can also provide a structured programme for the couples and provide hope and encouragement during times of progress and times of setback. The therapeutic relationship provides the opportunity for understanding the meaning of the vaginismus in the context of a woman's life and to address the reasons for this protective response. The therapeutic relationship can also provide an supportive and nurturing environment to address and to heal previously unmet emotional needs and to provide an opportunity connect with the self and with an intimate partner and to ultimately work towards resolving the vaginismus.

Chapter Conclusion

The theory presented in this thesis expands the current understanding of vaginismus by presenting it as a developmental process model. It suggests that the origin of the emotional and sexual difficulties that characterise vaginismus may be identified in a family context where emotional and sexual development is not perceived as supported. Feelings of shame and anxiety may necessitate the disconnection from, and repression of, emotional and sexual feelings and the development of psychosomatic defences, in this case, vaginismus. Deciding to enter into a couple relationship can be seen as a conscious effort to challenge these defences and to attempt to connect with the sexual and emotional self and to connect with an intimate partner within a secure relationship. The experience can often be a confusing and painful one, with endless and traumatic attempts at painful intercourse and little perceived support or information from medical professionals. Some couples may be successful in resolving the problem in their relationship and some will need additional support from a knowledgeable and empathic therapist that can provide a safe space for couples to connect with their emotional and sexual selves and claim ownership of their sexual relationship.

Evaluating the Emerging Theory

The evaluation of a grounded theory can be considered in terms of credibility, plausibility and applicability (Corbin & Strauss, 2015). When evaluating the credibility of an emerging theory, Glaser and Strauss (1967) recommend giving sufficient detail and description about the research process, how data was gathered and how analysis was conducted and to specify the kinds of data upon which interpretation sits that readers can follow how the researcher arrived at the findings and conclusions presented. The methodology chapter provides the reader with extensive detail about the sampling and recruitment criteria, the data collection design and procedures and analytic strategies for theory development and so can be considered to have fulfilled the criteria for credibility. The internal checks that were made throughout the study to ensure that the process undertaken adhered to Straussian grounded theory methodology are also documented in the methodology chapter to enhance credibility.

With regard to plausibility, grounded theory does not suggest that the theory presented is the only plausible one, simply the most plausible based on the data. The theory presented should be trustworthy and believable, reflecting the participants', researchers' and readers' experience (Corbin & Strauss, 2015). Both the methodology chapter and the results chapter provides the reader with a detailed description of each process of the emerging theory, drawing from the words of the participants and grounding the findings in their experience, and moving beyond a description of the experience of vaginismus in the Irish context to a theoretical framework that explains the phenomenon. The discussion chapter considers the key shared experiences that emerged from the data and situates them in the existing literature base, highlighting the unique findings of the study and how it contributes to the field of knowledge and practice. The detail provided allows the reader to evaluate whether the theory

is likely based on the interpretation of the research process presented and so this theory can be considered to have fulfilled the criteria for plausibility.

Corbin and Strauss suggest that applicability supersedes all other criteria for evaluation. With regard to applicability, the theory constructed should "provide insight, understanding and work with diverse populations and situations to bring about desired change" (Corbin & Strauss, 2015, p. 346). The theory should be useful because it explains the phenomenon under investigation and have application to bring about real change. Implications for theory, service provision and practice to bring about desired changes for those seeking to resolve vaginismus are also presented in the discussion chapter and so this theory can be considered to have fulfilled the criteria for applicability. In line with the pragmatic philosophical underpinnings of Straussian grounded theory, it is hoped that the objective of the research has been achieved; that it may have a beneficial impact for individuals, couples and health care providers and may lead to greater understanding of the vaginismus and more sensitive treatment by health care professionals.

When evaluating theory itself, Corbin and Strauss (2015) suggest that theory should elevate above mere description of a phenomenon by using an overarching structure or framework in order to explain why the phenomenon occurs. The theory presented here is unique in explaining the experience vaginismus in three non-linear interconnected developmental processes: protective disconnection, attempts and connection and healing connection through relationships within an Irish context. The protective disconnection process explains the factors in the culture and family of origin that can contribute to disconnection from the self, including the sexual self, and the development of the protective vaginismic response. The attempts at connection process explains, for the first time, the couple experience of vaginismus and attempts at help seeking in the Irish context. The healing connection through relationships process explains why the couple relationship and the

therapeutic relationship can be instrumental in facilitating connection to the sexual self and the resolution of vaginismus.

The theory also presents these processes within a particular cultural context using layers of influence based on Bronfenbrenner’s (1994) bioecological model. The woman, and later the couple, at the centre of the model are surrounded by concentric circles that represent cultural, national, local and familial layers of influence. The theory presented here takes a biopsychosocial orientation, integrating the physical, psychological and social influences that contribute to vaginismus but places a particular emphasis on the social factors, which have been identified as the least explored by research into sexual dysfunction (Atallah et al., 2016). The experience of vaginismus presented here is embedded within a particular socio-cultural context that not only represents the substantive context in which the data was collected, but is applicable to a diverse range of situations (Glaser & Strauss, 1967), allowing for a range of experiences within the Irish context to be represented.

N. Darling (2007) has criticised the application of Bronfenbrenner’s theory that neglects the person at the centre of the layers of influence. She suggests that the person is an active force in their development, evoking and reacting to responses from others creating “ecological niches in which distinct processes and outcomes will be observed” (p. 204). Like Bronfenbrenner’s model, the model of vaginismus in the Irish context presented here is dynamic and situates the woman’s process of development into a sexual being at the centre of the model and she both influences, and is influenced by, the layers of surrounding context. The findings of the study reveal that not every woman within these particular layers of influence will develop vaginismus and there is a dynamic interaction between the particular characteristics of the individual and the particular characteristics of the culture that interact to create the conditions for the development of vaginismus. Thus, this developmental model allows for the non-linear representation of multiple pathways of experience that contribute to the development, maintenance and resolution of vaginismus in the Irish culture.

It has been proposed that to understand the complexity of vaginismus it is necessary to examine it from intrapersonal, interpersonal and socio-cultural perspectives (Ng, 2010) and this model encompasses all of these aspects from intrapersonal accounts of the process of protective disconnection and attempts at connection, to interpersonal accounts of couples attempting to make a sexual connection and the role the therapeutic relationship can play in facilitating this connection, to descriptions of the socio-cultural contexts in which these processes of disconnection and connection occurs. This model of vaginismus is unique in giving consideration to the intrapersonal, intrapersonal and socio-cultural aspects of vaginismus and integrating them into a single unified theory. Thus, it contributes to filling significant gaps that have been identified in the literature and a more complete understanding of the complexities of vaginismus and the experiences of women and couples.

Limitations and Strengths of the Present Study

One limitation of the study is that the substantive theory of vaginismus developed is based specifically on the Irish context and so cannot claim grand theory status or generalisation to the experience of vaginismus for women outside of this context. Glaser and Strauss (1967), however, conceptualise the ability of grounded theory to produce a substantive theory rather than a grand theory as a strength rather than a weakness of the research because it resides within a particular context. According to Strauss and Corbin (1998), a substantive theory allows the researcher to progress from a description of the phenomenon to a theory of the process that explains the phenomenon within a particular context. This does not preclude generalisation to a diverse range of situations but it is beyond the scope of any one particular research study to claim an all-encompassing grand theory of a phenomenon (Glaser & Strauss, 1967). Further, Lincoln and Guba (1985) suggest that it is not necessarily the responsibility of the researcher to transfer the findings to another situation outside of the original study as long as the description of the study is sufficient to allow for

comparison. This study has produced a theory of the experience of vaginismus that is situated within the Irish context but can contribute to a body of knowledge that seeks to describe the phenomenon in the wider context.

A second limitation of this study is the homogenous profile of the couple participants sampled. Feminist object relations theory criticises the narrative of studies that reproduces the stories of Western, white heterosexual women on women in general (Aitken et al., 1996). Although not excluded from the recruitment process, no non-white women or couples applied to be interviewed, and the only lesbian couple who applied to participate later changed their minds about being interviewed. It was also not possible to interview women and couples who grew up in Northern Ireland and so the findings of this study cannot be generalised to all Irish women. The application of this study is therefore limited to the experience of vaginismus for Irish women and couples who reside in the Republic of Ireland and are white and of heterosexual orientation. The findings cannot be generalised to lesbian couples, non-white couples, or to couples where the woman did not grow up in the Republic of Ireland whose experience of vaginismus may be quite different from those of the couple participants interviewed for this study.

A third limitation considers the recruitment procedures for the couple participants. Various print, audio and social media channels were used to raise awareness about the study and couples contacted the researcher to volunteer for the study. Convenience sampling was used to gather the most relevant data by selecting from those who are readily available to be interviewed (Strauss & Corbin, 1998). According to Dyregrov et al. (2011), few studies have evaluated the motivation of participants in experiments, particularly those from vulnerable populations. The authors found that the majority of participants in their study about bereavement were altruistically motivated to help others and that this represented an adaptive coping strategy. Others were motivated by a desire to vent, while others sought insight into their difficult experiences. They suggested that all of the volunteer participants had had time

to reflect on their experience and may have been more emotionally detached than those who were more recently bereaved. Similarly, in this study, all of the couple volunteers had been together for more than three years and were quite knowledgeable about vaginismus and had a lot of experience in attending different services. Some of the couples had resolved the vaginismus at the time of the interview. Therefore, the experiences of the couples in this study cannot be generalised to those who are at an earlier stage of their relationship or of their understanding of vaginismus and help seeking.

Further, those who took part in the study had partners that were willing to support their partners by taking part of the interview. Eleven women who applied to take part in the study were ineligible to take part because their partner would not consent to be involved and so the experience of the generally sound and supportive couple relationship that was a feature of most of the couples in this study may not be generalisable to all couples experiencing vaginismus. Relationship satisfaction has not been linked to painful intercourse but this might be because relationships that end because of failed or painful sexual intercourse do not feature in research studies or go forward for therapeutic support (Meana et al., 2015).

A significant strength of this study is that the aim of developing a theoretical framework of the experience of vaginismus and help-seeking in Ireland was achieved. The theory makes a significant contribution to the literature and gives a voice to couple participants' experience of vaginismus and help seeking in Ireland. The ultimate test of whether this is achieved will be the extent to which it is considered useful. The study is unique in basing the theory in an Irish context and including perspectives of both couple and professional participants. The myriad of factors that may contribute to vaginismus is unique to each woman and couple and yet patterns were extracted from the data that suggests that there are some experiences that are characteristic of the experience of vaginismus in Ireland that allowed for the development of a substantive theoretical model. The experiences of women and couples are represented as a developmental process model that provides an insight into the women and couples who

experience vaginismus and the journey to resolve the difficulty. This theoretical model makes a unique contribution to the literature on vaginismus. This model of vaginismus is the first of its kind to represent the intrapersonal, intrapersonal and socio-cultural aspects of vaginismus and integrate these perspectives into a single unified theory.

A second strength of this study is the objective set out in the introduction was achieved: to have a beneficial impact for individuals, couples and health care providers and that may lead to greater understanding of the condition and more sensitive treatment by health care professionals. The pragmatist philosophy of Straussian grounded theory includes a sense of social responsibility not just to generate theory but to use it to benefit participants (Strauss & Corbin, 1998). One of the main difficulties experienced by participants was the isolation and shame experienced because of a lack of awareness about vaginismus that led them to believe that their experience was relatively unique. Throughout the research process, efforts were made to raise awareness of vaginismus through magazine and newspaper articles, a radio interview, social medical channels, recruitment posters in healthcare settings and a dedicated website that included information about vaginismus and services. The study also offered referrals to couples who had not resolved their vaginismus at the time of interview and so participation in the study not only empowered them to share their experiences but provided them with practical help and support to enable them to resolve the vaginismus.

A third strength of this study is that the voice of couples was foregrounded in providing insight into the experience of vaginismus. The Straussian grounded theory method chosen for analysis allows the researcher to describe experience from the perspective of participants and to situate the study in a particular sociocultural context (Strauss & Corbin, 1998). In the Irish culture of silence and shame surrounding sexual matters elucidated in this thesis, this study empowered the participants to share their experiences and to be heard in their own words through the use of direct quotes and the grouping of common experiences. The study is also unique in including the perspective of the partner. The lack of partner data in the literature

thus far as significantly impacted on what can be known about the experience of vaginismus for couples and the role that the partner can play in its resolution. The data presented here contributes to a greater understanding and fills a substantial gap in the literature.

Suggestions for future research would include the need for more qualitative studies that may provide a deeper understanding of vaginismus. Donaldson and Meana (2011) suggest, for example, that qualitative studies could provide an opportunity to understand how women conceptualise their experience of intercourse and pain. Interpretative phenomenological analysis could be used to explore the particular meanings that the experience of vaginismus holds for participants. Discourse analysis could focus on the commonalities and discrepancies in language between professionals and women and couple participants and how these construct the psychosocial reality of their experience of vaginismus. Such studies could include more diverse sample to include lesbian couples, non-white and non-national couples to expand the understanding of the experience of vaginismus and seeking help in the Ireland and beyond.

Concluding Remarks

In conclusion, this study has achieved its original aims and objectives of developing a theoretical framework of the experience of vaginismus and help-seeking in Ireland to provide a greater understanding of the condition for individuals, couples and professionals and more sensitive treatment by health care professionals. The experience of vaginismus in the Irish context was outlined as three processes: protective disconnection, attempts and connection and healing connection through relationships. These findings were explored in the context of existing literature and the unique contributions of this study were highlighted. The use of direct quotes from professional and couple participants provided a rich thick description of the experience of vaginismus and the privileging of couple data gave a voice to the couple experience that is largely absent from the existing literature.

The chapter concludes with the comments made by the couples who chose do follow up interviews and who had time to reflect on their experiences of speaking about vaginismus and help seeking and the interview process itself. Couple Sadhbh & Fionn had resolved their vaginismus at the time of the interview. Sadhbh, in her closing remarks said, "Because [vaginismus] is such an isolating situation to be in …I felt very positive about doing the interview." Her partner Fionn said "If my bit can help some other people, I would be very grateful…I don't want people to go through the situation we have gone through…obviously we were strong enough to kind of come through this together." Couple Medb and Alill had not resolved the vaginismus at the time of the interview but after the interview had made an appointment with a psychosexual counsellor. Medb said of her experience of the interview, "It was a difficult thing to do…but your questions were good and I suppose they made me think about things that I hadn't thought about for a long time…it spurred me on to take a bit of action." She said of her husband Alill's involvement, "It was good for me to look into it and just to hear my husband talking as well because again it is something that we…it is a bit of a difficult subject." Couple Cliodhna and Ciabhan had not resolved the vaginismus at the time of the interview. Ciabhan said he was happy to take part in the interview, "If it is going to help…there was no problem with privacy so I felt it was a positive step." His partner Cliodhna said,

> It's good to kind of get it off your shoulders, 'cos sometimes you only have your partner to talk to about it…it's good actually to get it out there and maybe there's other girls that's my age or older, sitting at home wondering is there any more help, and then you just need to come forward and say it so you are helping them as well as helping yourself.

References

Abbott, D. A., Springer, P. R., & Hollist, C. S. (2012). Therapy with immigrant muslim couples: Applying culturally appropriate interventions and strategies. *Journal of Couple and Relationship Therapy*, *11*, 254-266.

Adler, H. M. (2002). The sociophysiology of caring in the doctor-patient relationship *Journal of General Internal Medicine*, *17*, 883-890.

Ahmed, L. (1993). *Women and gender in Islam: Historical roots of a modern debate*. Yale University Press.

Ainsworth, M. D. S., & Bell, S. M. (1979). Attachment, exploration, and separation: Illustrated by the behavior of one-year-olds in a strange situation. *Child Development*, *41*(1), 49-67.

Ainsworth, M. D. S., & Bowlby, J. (1991). An ethological approach to personality development. *American Psychologist*, *46*(4), 333-341.

Aitken, G., Burman, E., Allldred, P., Billington, T., Allwood, R., Goldberg, B., Lopez, G., Debs, M., & Warner, S. (1996). *Psychology discourse practice: From regulation to resistance*. Taylor & Francis.

Akhavan-Taghavi, M. H., Asghari-Moghaddam, M. A., Froutan, S. K., & Jadid-Milani, M. (2015). Vaginismus in Iran: A single center report of 7 years experience. *Nephrology and Urology*, *7*(6), e30077.

Al-Abbadey, M., Liossi, C., Curran, N., Schoth, D. E., & Graham, C. A. (2016). Treatment of female sexual pain disorders: A systematic review. *Journal of Sex and Marital Therapy*, *42*, 99-142.

Allen, J. P., Grande, L., Tan, J., & Loeb, E. (2018). Parent and peer predictors of change in attachment security from adolescence to adulthood. *Child Development*, *89*(4), 1120-1132.

Allen, J. P., & Miga, E. M. (2010). Attachment in adolescence: A move to the level of emotion regulation. *Journal of Social and Personal Relationships*, *27*(2), 181-190.

Althof, S. (2010). Sex therapy: Advances in paradigms, nomenclature, and treatment. *Academic Psychiatry*, *34*, 390-396.

Alvesson, M., & Skoldberg, K. (2000). *Reflexive methodology: New vistas for qualitiave research*. Sage.

Amidu, N., Owiredu, W. K., Woode, E., Addai-Mensah, O., Quaye, L., Alhassan, A., & Tagoe, E. A. (2010). Incidence of sexual dysfunction: A prospective survey in Ghanaian females. *Reprodictove Biology Endocrinology*, *8*.

Amidu, N., Owiredu, W. K. B. A., Gyasi-Sarpong, C. K., Wood, E., & Quaye, L. (2011). Sexual dysfunction among married couples living in Kumasi metropolis, Ghana. *BMC Urology*, *11*(3), online publication.

Anastasiadis, A. G., David, A. R., Ghafar, M. A., Burchardt, M., & Shabsigh, R. (2002). The epidemiology and definition of female sexual disorders. *World Journal of Urology*, *20*, 74-78.

APA. (1994). *Diagnostic and statistical manual of mental disorders* (4 ed.). American Psychiatric Association.

APA. (2000). *Diagnostic and statistical manual of mental disorders* (4-Text Revision ed.). American Psychiatric Association.

APA. (2013). *Diagnostic and statistical manual of mental disorders* (5 ed.). American Psychiatric Association.

Arcelus, J., & Wales, J. (2009). Partial vaginismus and anorexia nervosa: A case report. *Sexual and Relationship Therapy*, *24*(3-4), 368-372.

Arriaga, X. B., & Kumashiro, M. (2019). Walking a security tightrope: Relationship induced changes in attachment security. *Current Opinion in Psychology*, *25*, 121-126.

Aslan, M., Yavuzkir, S., & Baykara, S. (2020). Is "dilator use" more effective than "finger use" in exposure therapy in vaginismus treatment. *Journal of Sex and Marital Therapy*, *46*(4), 354-360.

Atallah, S., Johnson-Agbakwu, C., Rosenbaum, T., Abdo, C., Byers, E. S., Graham, C., Nobre, P., Wylie, K., & Brotto, L. (2016). Ethical and sociocultural aspects of sexual function and dysfunction in both sexes. *Journal of Sexual Medicine*, *13*, 591-606.

Bancroft, J. (2009). *Human sexuality and its problems*. Churchill Livingstone Elsevier.

Bancroft, J., Loftus, J., & Long, J. S. (2003). Distress about sex: A national survey of women in heterosexual relationships. *Archives of Sexual Behaviour*, *32*, 193-211.

Barmak, S. (2018). The misunderstood science of sexual desire. *The Cut*, *April 26 (Online)*. https://www.thecut.com/2018/04/the-misunderstood-science-of-sexual-desire.html?utm_source=tw

Barnes, J. (1986a). Primary vaginismus (part 1): Social and clinical features. *Irish Medical Journal*, *79*(3), 59-62.

Barnes, J. (1986b). Primary vaginismus (part 2): Aetiological factors. *Irish Medical Journal*, *79*(3), 62-65.

Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology*, *61*(2), 226-244.

Basson, R. (2008a). Clinical focus: Women's sexual desire and arousal disorders. *Primary Psychiatry*, *15*(9), 77-86.

Basson, R. (2008b). Women's sexual function and dysfunction: Current uncertainties, future directions. *Int J Impot Res*, *20*, 466–478.

Basson, R. (2011). The female sexual response: A different model. *Journal of Sex and Marital Therapy*, *26*(1), 51-65.

Basson, R., Althof, S., Davis, S., Fugl-Meyer, K., Goldstein, I., Leiblum, S., Meston, C., Rosen, R., & Wagner, G. (2004). Summary of the recommendations on sexual dysfunctions in women. *Journal of Sexual Medicine*, *1*(1), 24-34.

Basson, R., Berman, J., Burnett, A., Derogatis, L., Ferguson, D., Fourcroy, J., Goldstein, I., Graziottin, A., Heiman, J., Laan, E., Leiblum, S., Padma-Nathan, H., Rosen, R., Segraves, K., Segraves, R. T., Shabsigh, R., Sipski, M., Wagner, G., & Whipple, B. (2000). Report of the International Consensus Development Conference on female sexual dysfunction: Definitions and classifications. *Journal of Urology*, *163*, 888-893.

Basson, R., Leiblum, S., Brotto, L., Derogatis, L., Fourcroy, J., Fugl-Meyer, K., & Weijmar-Schultz, W. (2003). Definitions of women's sexual dysfunctions reconsidered: Advoating expansion and revision. *Journal of Psychosomatic Obstetrics & Gynaecology*, *24*(4), 221-229.

Basson, R., & Weijmar-Schultz, W. (2007). Sexual sequelae of general medical disorders. *The Lancet*, *369*, 409-424.

Ben-Zion, I., Rothschild, S., Chudakov, B., & Aloni, R. (2007). Surrogate versus couple therapy in vaginismus. *Journal of Sexual Medicine*, *4*(3), 728-733.

Berger, J. H., Kehoe, J. E., Doan, A. P., Crain, D. S., Klam, W. P., Marshall, M. T., & Christman, M. S. (2019). Survey of sexual function and pornography. *Military Medicine*, *184*(11-12), 731-737.

Bergeron, S., Corsini-Munt, S., Aerts, L., Rancourt, K., & Rosen, N. O. (2015). Female sexual pain disorders: A review of the literature on etiology and treatment. *Current Sexual Health Reports*, *7*, 159–169.

Bergeron, S., Khalife, S., Glazer, H. I., & Binik, Y. M. (2007). Surgical and behavioural treatments for vestibulodynia: Two-and-one-half-year follow-up and predictors of outcome. *Obstetrics and Gynaecology*, *111*(1), 159-166.
Bergeron, S., & Lord, M. J. (2003). Leading comment: The integration of pelvi-perineal re-education and cognitive-behavioural therapy in the multidisciplinary treatment of the sexual pain disorders. *Sexual and Relationship Therapy*, *18*(2), 135-141.
Bergeron, S., Rosen, N. O., & Pukall, C. F. (2014). Genital pain in women and men: It can hurt more than your sex life. In K. S. K. Hall & Y. M. Binik (Eds.), *Principles and Practice of Sex Therapy* (pp. 159-176). The Guilford Press.
Berman, J. R., Berman, L. A., & Goldstein, I. (1999). Female sexual dysfunction: Incidence, pathophysiology, evaluation, and treatment options. *Urology*, *15*(43), 385–391.
Bernstein, D. (1990). Female genital anxieties, conflicts and typical masterly modes. *International Journal of Psychoanalysis*, *71*, 155-165.
Biernacki, P., & Waldorf, D. (1981). Snowball sampling: Problems and techniques of chain referral sampling. *Sociological Methods and Research*, *10*(2 November), 141-163.
Bigras, N., Daspe, M., Godbout, N., & Sabourin, S. (2016). Cumulative childhood trauma and adult sexual satisfaction: Mediation by affect dysregulation and sexual anxiety in men and women. *Journal of Sex and Marital Therapy*, *Online*.
Binik, Y. M. (2010). The DSM diagnostic criteria for vaginismus. *Archives of Sexual Behaviour*, *39*(2), 278-291.
Binik, Y. M. (2014). Will vaginismus remain a "lifelong" baby? Response to Reissing et al. (2014). *Archives of Sexual Behaviour*, *43*, 1215-1217.
Binik, Y. M., & Meana, M. (2009). The future of sex therapy: Specialization or marginalization? *Archives of Sexual Behaviour*, *38*, 1016-1027.
Binik, Y. M., Meana, M., Berkley, K., & Khalife, S. (1999). The sexual pain disorders: Is the pain sexual or is the sex painful? *Annual Review of Sex Research*, *10*(1), 210-235.
Binik, Y. M., Pukall, C. F., Reissing, E. D., & Khalife, S. (2001). The sexual pain disorders: A desexualised approach. *Journal of Sexual and Maritial Thearpy*, *27*, 113-116.
Biswas, A., & Ratnam, S. S. (1995). Vaginismus and outcome of treatment. *Annals of the Academy of Medicine*, *24*(5), 755-758.
Boa, R. (2013). Female sexual pain disorders. *Obstetric and Gynaecology Forum*, *23*, 27-31.
Bodenmann, G., Ledermann, T., Blattner, D., & Galluzzo, C. (2006). Associations among everyday stress, critical life events, and sexual problems. *The Journal of Nervous and Mental Disease*, *192*(7), 494-501.
Bodenreider, O., Smith, B., & Burgun, A. (2004). The ontology-epistemology divide: A case study in medical terminology. In A. C. V. L. Vieu (Ed.), *Proceedings of the Third International Conference on Formal Oncology in Information Systems* (pp. 185-195).
Bois, K., Bergeron, S., Rosen, N., Mayrand, M. H., Brassard, A., & Sardikaj, G. (2016). Intimacy, sexual satisfaction, and sexual distress in vulvodynia couples: An observational study. *Health Psychology*, *35*(6), 531-540.
Borg, C., de Jong, P. J., & Weijmar-Schultz, W. (2010a). Vaginismus and dyspareunia: Automatic vs. deliberate disgust responsivity. *Journal of Sexual Medicine*, *7*(6), 2149-2157.
Borg, C., de Jong, P. J., & Weijmar-Schultz, W. (2010b). Vaginismus and dyspareunia: Relationship with general and sex-related moral standards. *Journal of Sexual Medicine*, *8*, 223-231.
Borg, C., Peters, M. L., Weijmar-Schultz, W., & de Jong, P. J. (2012). Vaginismus: Heightened harm avoidance and pain catastrophizing cognitions. *Journal of Sexual Medicine*, *9*(2), 558-567.
Bothe, B., Toth_Kiraly, I., Griffiths, M. D., Potenza, M. N., Orosz, G., & Demetrovics, Z. (2021). Are sexual functioning problems associated with frequent pornography use

and/or problematic pornography use? Results from a large community survey including males and females. *Addictive Behaviours*, *112*, 1-9.
Bowlby, J. (1973). *Attachment and loss. Vol 2: Separation, anxiety and anger*. Basic Books.
Bronfenbrenner, U., & Ceci, S. J. (1994). Nature-nurture reconceptualised in developmental perspective: A bioecological model. *Psychological Review*, *101*(4), 568-586.
Bronfenbrenner, U., & Morris, P. A. (1998). The Ecology of Developmental Processes. In W. Damon & R. M. Lerner (Eds.), *Handbook of child psychology: Theoretical models of human devleopment.* (pp. 993-1028). John Wiley & Sons Ltd.
Brown, L. S. (2009). Cultural competence: A new way of thinking about integration in therapy. *Journal of Psychotherapy Integration*, *19*(4), 340-353.
Brown, R. J., Schrag, A., & Trimble, M. R. (2005). Dissociation, childhood interpersonal trauma and family functioning with patients with somatisation disorder. *American Journal of Psychiatry*, *162*(5), 899-905.
Bryant, A. (2002). Re-grounding grounded theory. *Journal of Information Technology Theory and Application*, *4*(1), 25-42.
Bryman, A. (2004). *Social Research Methods, 2nd Edition*. Oxford Universtity Press.
Buchheim, A., Erik, S., George, C., Kachele, H., Ruchsow, M., Spritzer, M., Kircher, T., & Walter, H. (2006). Measuring attachment representation in an fMRI environment: A pilot study. *Psychopathology*, *39*, 144-152.
Burton, M. (2017). *The journey from religiosity to spirituality and the impact on a woman's sexuality: A phenomenological study* [Msc., Christian Heritage College]. Australia.
Butler, C., & Joyce, V. (1998). *Counselling couples in relationships: An introduction to the Relate approach*. Wiley.
Byrne, M., Doherty, S., McGee, H., & Murphy, A. W. (2010). General practitioner views about discussing sexual issues with patients with coronary heart disease. *BMC Family Practice*, *11*(40), 1-7.
Cacchioni, T., & Wolkowitz, C. (2011). Treating women's sexual difficulties: The body work of sexual therapy. *Sociology of Health and Illness*, *33*(2), 266-279.
Canin, N. (2006). *The experiences and perceptions of women suffering from vaginismus* [M.A., University of the Witwatersrand]. South Africa.
Carr, K., & Wilder, S. E. (2016). Attachment style and the risks of seeking social support: Variations between friends and siblings. *Southern Communication Journal*, *81*(5), 316-329.
Catania, J. A., Pollack, L., McDermott, L. J., Qualls, S. H., & Cole, L. (1990). Help-seeking behaviours of people with sexual problems. *Archives of Sexual Behaviour*, *19*, 235-250.
Charmaz, K. (2003). Grounded theory: Objectivist and constructivist methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *Strategies of qualitative enquiry* (2 ed., pp. 249-291). Sage.
Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Sage.
Charmaz, K. (2009). Shifting the grounds: Constructivist grounded theory methods. In J. M. Morse, P. Noerager Stern, J. Corbin, B. Bowers, K. Charmaz, & A. E. Clarke (Eds.), *Developing grounded theory: The second generation*. Left Coast Press.
Charmaz, K. (2015). *Constructing grounded theory, 2nd Edition* (2 ed.). Sage.
Cherner, R. A., & Reissing, E. D. (2013). A comparative study of sexual function, behaviour, and cognitions of women with lifelong vaginismus. *Archives of Sexual Behaviour*, *42*(8), 1605-1614.
Chesler, P. (1997). *Women and madness*. Four Walls, Eight Windows.
Chodorow, N. (1989). *Feminism and psychoanalytic theory*. Yale University Press.

Ciocca, G., Limoncin, E., Di Tommaso, S., Mollaioli, D., Gravina, G. L., Marcozzi, A., Tullii, A., Carosa, E., Di Sante, S., Gianfrilli, D., Lenzi, A., & Jannini, E. A. (2014). Attachment styles and sexual dysfunctions: A case-control study of female and male sexuality. *Int J Impot Res*, *47*, 81-85.

Clegg, M., Pye, J., & Wylie, K. R. (2016). Undergraduate training in human sexuality - Evaluation of the impact on medical doctor's practice ten years after graduation. *Sexual Medicine*, *4*, 198-208.

Clegg, M., Towner, A., & Wylie, K. (2012). Should questionnaire of female sexual dysfunction be used in routine practice? *Maturitas*, *72*, 160-164.

Clulow, C., & Boerma, M. (2009). Dynamics and disorders of sexual desire. In C. Clulow & P. Fonagy (Eds.), *Sex, attachment and couple psychotherapy: A psychoanalytic perspective*. Karnac.

Clulow, C., & Fonagy, P. (2009). *Sex, attachment and couple psychotherapy: A psychoanalytic perspective*. Karnac.

Coan, J. A., Schaefer, H. S., & Davidson, R. J. (2006). Lending a hand: Social regulation of the neural response to threat. *Psychological Science*, *17*, 1032-1039.

Coleman, E., Elders, J., Satcher, D., Shindel, A., Parish, S., Kenagy, G., Roth Bayer, C., Knudson, G., Kingsberg, S., Clayton, A., Lunn, M. R., Goldsmith, E., Tsai, P., & Light, A. (2013). Summit on medical education in sexual health: Report of an expert consultation. *Journal of Sexual Medicine*, *10*, 924-938.

Colman, W. (2009). What do we mean by sex? In C. Clulow & P. Fonagy (Eds.), *Sex, attachment and couple psychotherapy: A psychoanalytic perspective*. Karnac.

Compston, H. (2006). Sexual liberalisation. *King Trends and Future Public Policy*, 291-301.

Cooney, A. (2010). Choosing between Glaser and Strauss: An example. *Nurse Researcher*, *17*(4), 18-28.

Coppini, A. (1999). A case of primary vaginismus. *International Forum of Psychoanalysis*, *8*, 49-52.

Corbin, J., & Morse, J. M. (2003). The unstructured interactive interview: Issues of reciprocity and risks when dealing with sensiitive topics. *Qualitative Inquiry*, *9*(3), 335-354.

Corbin, J., & Strauss, A. (2015). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Sage.

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Sage.

Creswell, J. W. (2013). *Qualitative inquiry and research design: choosing among five approaches* Sage.

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five traditions* (4 ed.). SAGE.

Crittenden, P. M. (2006). A dynamic-maturational model of attachment. *Australian and New Zealand Journal of Family Therapy*, *27*(2), 105-115.

Cromme, S. K., Whitaker, K. L., Winstanley, K., Renzi, C., Friedermann-Smith, C., & Wardle, J. (2016). Worrying about wasting GP time as a barrier to help-seeking: A community-based, qualitative study. *British Journal of General Practice*, *66*(648), 474-482.

Crowley, T., Goldmeier, D., & Hiller, J. (2009). Diagnosing and managing vaginismus. *British Medical Journal*, *338*, b2284.

Crowley, T., Richardson, D., & Goldmeier, D. (2006). Recommendations for the management of vaginismus: BASHH Special Interest Group for Sexual Dysfunction. *International Journal of STD and Aids*, *17*(1), 14-18.

D'Eath, M., Byrne, M., Doherty, S., McGee, H., & Murphy, A. W. (2013). The cardiac health and assessment of rleationship management and sexuality study: A qualitative inquiry

of patient, general practitioner, and cardiac rehabilitation staff views on sexual assessment and counselling for cardiac patients. *Journal of Cardiovascular Nursing*, *28*(2), E1-E13.

Darawsheh, W. (2014). Reflexivity in research: Promoting rigour, reliability and validity in qualitative research. *International Journal of Therapy and Rehabilitation*, *21*(12), 560-568.

Darling, C. A., & Hicks, M. W. (1982). Parental influence on adolescent sexuality: Implications for parents as educators. *Journal of Youth and Adolescence*, *11*(3), 231-245.

Darling, N. (2007). Ecological systems theory: The person in the centre of the circles. *Research in Human Development*, *4*(3-4), 203-217.

Darrouzet-Nardi, J., & Hatch, A. (2014). Women's experiences negotiating sexual scripts in the face of sexual difficulties. *Electronic Journal of Human Sexuality*, *17*.

Dattilio, F. M. (2010). *Cognitive-behavioural therapy with couples and families: A comprehensive guide for clinicians*. Guilford Press.

Davis, H. J., & Reissing, E. D. (2007). Relationship adjustment and dyadic interaction in couples with sexual pain disorders: A critical review of the literature. *Sexual and Relationship Therapy*, *22*(2), 245-254.

Dawson, K., NicGabhainn, S., & MacNeela, P. (2018). Dissatisfaction with school sex education is not associated with using pornography for sexual information. *Porn Studies*, *6*, 245-257.

DCU. (2018). *Dublin City University data handling guidelines*. Dublin City University.

DCYA. (2017). *Children First: National guidance for the protection and welfare of children*. DCYA.

de Jong, P. J., van Overveld, M., Weijmar-Schultz, W., Peters, M. L., & Buwalda, F. M. (2009). Disgust and contamination sensitivity in vaginismus and dyspareunia. *Archives of Sexual Behaviour*, *38*(2), 244-252.

de Souza, M. C. B., Gusmao, M. C. G., Antunes, R. A., de Souza, M. M., Rito, A. L. S., Lira, P., Macebo, A. C. A., Tamm, M. A., Panaino, T. R., & Bahia, M. J. (2018). Vaginismus in assisted reproductive technology centers: An invisible population in need of care. *JBRA Assisted Reproduction*, *22*(1), 35-41.

Dempsey, L., Dowling, M., Larkin, P., & Murphy, K. (2016). Sensitive interviewing in qualitative research. *Research in Nursing and Health*, *39*, 480-490.

Denman, C. (2004). *Sexuality: A Biopsychosocial Approach*. Palgrave Macmillan.

Denscombe, M. (2002). *Ground rules for good research : A 10 point guide for social researchers*. Open University Press.

Devers, K. J., & Frankel, R. M. (2000). Study design in qualitative ressearch-2: Sampling and data collection strategies. *Education for health*, *13*(2), 263-271.

Devinsky, O. (2000). Right cerebral hemisphere dominane for a sense of corporeal and emotional self. *Epilepsy and Behaviour*, *1*, 60-73.

Dias-Amaral, A., & Marques-Pinto, A. (2018). Female genito-pain/penetration disorder: Review of the related factors and overall approach. *The Brazilian Journal of Gynecology and Obstetrics*, *40*, 787-793.

Dickson-Swift, V., James, E. L., & Kippen, S. (2005). Do universtiy ethics committees adequately protect public health researchers? *Australian and New Zealand Journal of Public Health*, *29*(6), 576-579.

DiIorio, C., Kelley, M., & Hockenberry-Eaton, M. (1999). Communication about sexual issues: Mothers, fathers and friends. *Journal of Adolescent Health*, *24*, 181-189.

DiMascio, A., Boyd, R., & Greenblatt, M. (1957). Physiological corelates of tension and antagonism during psychotherapy: a study of "interpersonal physiology". *Psychosomatic Medicine*, *19*, 99-104.

Dittus, P. J., & Jaccard, J. (2000). Adolescents' perceptions of maternal disapproval of sex: Relationship to sexual outcomes. *Journal of Adolescent Health*, *26*, 268-278.
Dogan, S. (2009). Vaginismus and accompanying sexual dysfunctions in a Turkish clinical sample. *Journal of Sexual Medicine*, *6*(1), 184-192.
Dogan, S., & Dogan, M. (2008). The frequency of sexual dysfunctions in male partners of women with vaginismus in a Turkish sample. *Int J Impot Res*, *20*(2), 218-221.
Dogan, S., & Varol-Saracoglu, G. (2009). The assessment of sexual knowledge, marital characteristics, sexual function and satisfaction in women with lifelong vaginismus. *Medical Journal of Trakya University*, *26*(2), 151-158.
Dolan, L. (2009). An integrative approach to the psychotherapeutic treatment of vaginismus incorporating hypnosuggestion and hypnoanalysis. *Australian Journal of Clinical and Experimental Hypnosis*, *37*(1), 60-73.
Donaldson, R. L., & Meana, M. (2011). Early dyspareunia experiences in young women: Confusion, consequences and help-seeking barriers. *Journal of Sexual Medicine*, *8*, 814-823.
Drenth, J. J. (1988). Vaginismus and the desire for a child. *Journal of Psychosomatic Obstetrics and Gynecology*, *9*(2), 125-137
Drenth, J. J., Andriessen, S., Heringa, M. P., Mourits, M. J. E., van de Wiel, H. B. M., & Weijmar-Schultz, W. C. M. (1996). Connections between primary vaginismus and procreation: Some observations from clinical practice. *Journal of Psychosomatic Obstetrics and Gynecology*, *17*(4), 195-201.
DuBois, J. M., Beskow, L., Campbell, J., Dugosh, K., Festinger, D., Hartz, S., James, R., & Lidz, C. (2012). Restoring balance: A consensus statement on the protection of vulnerable research participants. *American Journal of Public Health*, *102*(12), 2220-2225.
Ducat, W. H., & Zimmer-Gembeck, M. J. (2010). Romantic partner behaviours as social context: Measuring six dimensions of relationship. *Journal of Relationships Research*, *1*, 1-16.
Dyregrov, K., Dieserud, G., Straiton, M., Lyberg Rasmussen, M., Hjeleland, H., Knizek, B. L., & Leenaars, A. A. (2011). Motivation for research participation among people bereaved by suicide. *Omega*, *62*(2), 149-168.
Eagly, A. H., & Chaiken, S. (1998). Attitude structure and function. In D. T. Gilbert, S. T. Fiske, & G. Lindzey (Eds.), *The handbook of social psychology* (pp. 269-322). McGraw-Hill.
Ecclestone, K., & Hayes, D. (2009). *The dangerous rise of therapeutic education*. Routledge.
Eichenbaum, L., & Orbach, S. (1982). *Outside in, inside out: Women’s psychology - a feminist psychoanalytic approach*. Pelican Books.
Eisenberger, N. I. (2012). The pain of social disconnection: Examining the shared neural underpinnings of physical and social pain. *Neuroscience*, *13*(June), 421-434.
Elliott, R., & Timulak, L. (2005). Descriptive and interpretive approaches to qualitative research. In J. Miles & P. Gilbert (Eds.), *A handbook of research methods for clinical and health psychology* (pp. 147-159). Oxford University Press.
Elmerstig, E., Wijma, B., & Bertero, C. (2008). Why do young women continue to have sexual intercourse despite pain? *Journal of Adolescent Health*, *43*(4), 357-363.
Elo, S., Kaariainen, M., Kanste, O., Polkki, T., Utriainen, K., & Kyngas, H. (2014). Qualitative content analysis: A focus on trustwothiness. *Sage Open*(January-March), 1-10.
Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Sciencw*, *196*(4286), 129-136.
Engman, M., Lindehammar, H., & Wijma, B. (2004). Surface electromyography diagnostics in women with partial vaginismus with or without vulvar vestibulitis and in

asymptomatic women. *Journal of Psychosomatic Obstetrics and Gynecology*, *25*(3-4), 281-294.
Engman, M., Wijma, K., & Wijma, B. (2010). Long-term coital behaviour in women treated with cognitive behaviour therapy for superficial coital pain and vaginismus. *Cognitive Behavioural Therapy*, *39*(3), 193-202.
Fagan, P. (2004). *Sexual disorders: perspectives on diagnosis and treatment*. John Hopkins University.
Fageeh, W. M. (2011). Different treatment modalities for refractory vaginismus in western Saudi Arabia. *Journal of Sexual Medicine*, *8*(6), 1735-1739.
Fajewonyomi, B. A., Orji, E. O., & Adeyemo, A. O. (2007). Sexual dysfunction among female patients of reproductive age in a hospital setting in Nigeria. *Journal of Health and Population Nutrition*, *25*(1), 101-106.
Farnam, F., Janghorbani, M., Merghati-Khoei, E., & Raisi, F. (2014). Vaginismus and its corrrelates in an Iranian clinical sample. *Int J Impot Res*, *26*, 230-234.
Farrell, J., & Cacchioni, T. (2012). The medicalization of women's sexual pain. *Journal of Sex Research*, *49*(4), 328-336.
Ferriter, D. (2009). *Occasions of sin: Sex and society in modern Ireland*. Profile Books.
Frasson, E., Graziottin, A., Priori, A., Dall'ora, E., Didone, G., Garbin, E. L., Vicentini, S., & Bertolasi, L. (2009). Central nervous system abnormalities in vaginismus. *Clinical Neurophysiology*, *120*(1), 117-122.
Frost, N. (2011). *Qualitative research methods in psychology: Combining core approaches*. McGraw-Hill.
Fugl-Meyer, K. S., Bohm-Starke, N., Damsted Petersen, C., Fugl-Meyer, A., Parish, S., & Giraldi, A. (2012). Standard operating procedures for female genital sexual pain. *Journal of Sexual Medicine*, *10*(1), 83-93.
Gillham, B. (2005). *Research interviewing: The range of techniques*. McGraw-Hill.
Gillooly, J. B. (2008). Making menarche positve and powerful for both mother and daughter. *Women and Therapy*, *27*(3-4), 23-35.
Glaser, B. G. (2002). Conceptualisation: On theory and theorizing using grounded theory. *International Journal of Qualitative Methods*, *1*(12), 23-38.
Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Aldine De Gruyter.
Graziottin, A. (2008). Dyspareunia and vaginismus: Review of the literature and treatment. *Current Sexual Health Reports*, *5*, 43-50.
Graziottin, A. (2009). Dyspareunia and vaginismus: What the gynaecologist should not miss. *International Journal of Gynaecology and Obstetrics*, *107*(2), S33-S34.
Graziottin, A. (2010). Menopause and sexuality: Key issues in premature menopause and beoyond. *Annals of the New York Academy of Sciences*, *1205*(Women's Health and Disease), 254-261.
Greenstein, A., Abramov, L., Matzkin, H., & Chen, J. (2006). Sexual dysfunction in women partners of men with erectile dysfunction. *Int J Impot Res*, *18*(1), 44-46.
Greenwood, J. (1992). Reflective practice: A critique of the work of Argyris and Schon. *Journal of Advanced Nursing*, *18*, 1183-1187.
Gubrium, J. F., & Holstein, J. A. (2003). Analysing interpretive practice. In N. K. Denzin & Y. S. Lincoln (Eds.), *Strategies of qualitative inquiry* (2 ed., pp. 214 - 248). Sage.
Haack, S., & Kolenda, K. (1977). Two fallibilists in search of truth. *Proceedings of the Aristotelian Society*, *51*(63-104).
Hadjistavropoulos, T., & Smythe, W. E. (2001). Elements of risk in qualitative research. *Ethics and Behaviour*, *11*(2), 163-174.

Hamidi, S., Shareh, H., & Kaveh Hojjar, S. (2015). Comparison of early maladaptive schemas and attachment styles in women with vaginismus and normal women. *The Iranian Journal of Obstetrics, Gynsecology and Infertility*, *18*, 155-156.
Hammersley, M. (1991). *Reading ethnographic research: A critical guide* (2 ed.). Longman.
Harish, T., Krishna Prasad, M., & Murthy, P. (2012). Successful management of vaginismus: An eclectic approach. *Indian Journal of Psychiatry*, *54*(4), 391.
Hawton, K. (1985). *Sex therapy: A practical guide*. Oxford University Press.
Hawton, K., & Catalan, J. (1990). Sex therapy for vaginismus: Characteristics of couples and treatment outcome. *Sexual and Marital Therapy*, *5*(1), 39-48.
Hazan, C., & Shaver, P. (1987). Romantic love conceptualized as an attachment process. *Journal of Personality and Social Psychology*, *52*(3), 511-524.
Heiman, J. R., & Meston, C. M. (1997). Empirically validated treatment for sexual dysfunction. *Annual Review of Sex Research*, *8*(1), 148-194.
Heinemann, J., Atallah, S., & Rosenbaum, T. (2016). The impact of culture and ethnicity on sexuality and sexual function. *Current Sexual Health Reports*, *8*(3), 144-150.
Henderson, P. (2013). Opinion piece: In praise of "ordinary" sex therapy. *Sexual and Relationship Therapy*, *29*(1), 132-134.
Herbert, A. C., Ramirez, A. M., Lee, G., North, S. J., Askari, M. S., West, R. L., & Sommer, M. (2017). Puberty experiences of low-income girls in the United States: A systematic review of qualitative literature from 2000-2004. *Journal of Adolescent Health*, *60*, 363-379.
Hilburn-Cobb, C. (2004). Adolescent psychopathology in temrs of multiple behavioural systems: The role of attachmnet and controlling strategies and frankly disorganised behaviour. In L. Atkinson & S. Goldberg (Eds.), *Attachment issues in psychopathology and intervention* (pp. 95-135). Lawrence Erlbaum Associates.
Hiller, J. (2000). Current debate: Defining vaginismus. *Sexual and Relationship Therapy*, *15*(1), 87-90.
Hinde, J. S., Parkes, C. M., & Stevenson-Hinde, J. (1982). *The place of attachment in human behaviour*. Tavistock.
Hirsch, M. (1981). Mothers and Daughters. *Signs*, *7*(Autumn), 200-222.
Holmes, J. (2000). Attachment theory and psychoanalysis: A rapprochement. *British Journal of Psychotherapy*, *17*(2), 157-172.
Hooper, D., & Dryden, W. (1991). *Couple therapy: A handbook*. Open University Press.
Huber, J. D., Pukall, C. F., Boyer, S. C., Reissing, E. D., & Chamberlain, S. M. (2009). "Just relax": Physicians' experiences with women who are difficult or impossible to examine gynecologically. *Journal of Sexual Medicine*, *6*, 791-799.
Hughes, J. A., & Sharrock, W. W. (1997). *The philosophy of social reasearch* (3 ed.). Pearson Education.
Huijding, J., Borg, C., Weijmar-Schultz, W., & de Jong, P. J. (2011). Automatic affective appraisal of sexual penetration stimuli in women with vaginismus or dyspareunia. *Journal of Sexual Medicine*, *8*(3), 806-813.
Humphrey, S., & Nazareth, I. (2001). GPs' views on their management of sexual dysfunction. *Family Practice*, *18*(5), 516-518.
Hunter, A., Murphy, K., Grelish, A., Casey, D., & Keady, J. (2011). Navigating the grounded theory terrain, part 1. *Nurse Researcher*, *18*(4), 6-10.
Hutchinson, M. K., Jemmott, J. B., Sweet-Jemmott, L., Braverman, P., & Fong, G. T. (2003). The role of mother-daughter sexual risk communication in reducing sexual risk behaivours among urban adolescent females: A prospective study. *Journal of Adolescent Health*, *33*, 98-107.
Hyde, A., & Howlett, E. (2004). *Understanding teenage sexuality in Ireland*. Crisis Pregnancy Agency.

ICGP. (2020). *ICGP curriculum for GP training in Ireland*. ICGP.
Ingles, T. (1998). *Lessons in Irish sexuality*. UCD Press.
Inglis, T. (2005). *Origins and legacies of Irish prudery: Sexuality ad social controls in modern Ireland*. Irish American Cultural Institute.
Jacob, S. A., & Furgerson, S. P. (2012). Writing interview protocols and conducting interviews: Tips for students new to the field of qualitative research. *The Qualitative Report*, *17*(42), 1-10.
Jaffe, A. E., DiLillo, D., Hoffman, L., Haikalis, M., & Dykstra, R. E. (2015). Does it hurt to ask? A meta-analysis of participant reactions to trauma research. *Clinical Psychology Review*, *40*, 40-56.
Jeng , C. J. (2004). The pathophysiology and aetiology of vaginismus. *Taiwanese Journal of Obstetrics and Gynaecology*, *43*(1), 10-15.
Jeng , C. J., Wang , L. R., Chou , C. S., Shen, J., & Tzeng, C. R. (2006). Management and outcome of primary vaginismus. *Journal of Sex and Marital Therapy*, *32*(5), 379-387.
Johnson, S., & Zuccarini, D. (2010). Integrating sex and attachment in emotionally focused couple therapy. *Journal of Marital and Family Therapy*, *36*(4), 4331-4445.
Kabakci, E., & Batur, S. (2003). Who benefits from cognitive behavioural therapy for vaginismus? *Journal of Sex and Marital Therapy*, *29*(4), 277-288.
Kaiser, K. (2009). Protecting respondent confidentiality in qualitative research. *Qualitative Health Research*, *19*(11), 1632-1641.
Kaneko, K. (2001). Penetration disorder: Dyspareunia exists on the extension of vaginismus. *Journal of Sex and Marital Therapy*, *27*, 153-155.
Karofsky, P. S., Zeng, L., & Kosorok, M. R. (2000). Relationship between adolescent-parental communication and initiation of first intercourse by adolescents. *Journal of Adolescent Health*, *28*, 41-45.
Katz, J., & Myhr, L. (2008). Percieved conflict patterns and relationship quality associated with verbal sexual coercion by male dating partners. *Journal of Interpersonal Violence*, *23*(6), 798-814.
Kellogg-Spadt, S., Rosenbaum, T. Y., Dweck, A., Millheiser, L., Pillai-Friedman, S., & Krychman, M. (2014). Sexual health and religion: A primer for the sexual health clinician. *Journal of Sexual Medicine*, *11*, 1606-1619.
Kenny, M., & Fourie, R. (2015). Contrasting classic, Straussian and constructivist grounded theory: Methodological and philosophical conflicts. *The Qualitative Report*, *20*(8), 1270-1289.
Kent, G. (2000). Ethical principles. In D. Burton (Ed.), *Research training for social scientists* (pp. 61-67). Sage.
Kessler, J. M. (1988). When the diagnosis Is vaginismus: Fighting misconceptions. *Women and Therapy*, *7*(2-3), 175-186.
Khan-Singh, J. (2019). The Psychosexual Genital Examination. In P. Brough & M. Denman (Eds.), *Introduction to Psychosexual Medicine* (pp. 109-118). Sage.
Kiely, E. (2005). Where is the discourse of desire? Deconstructing the Irish Relationships and Sexuality Education (RSE) resource materials. *Irish Educational Studies*, *24*(2-3), 253-266.
King, B. M., & Lousso, J. (1997). Discussions in the home about sex: Different recollections by parents and children. *Journal of Sex and Marital Therapy*, *23*(1), 52-60.
Klaassen, M., & Ter Kuile, M. M. (2009). Development and initial validation of the vaginal penetration cognition questionnaire (VPCQ) in a sample of women with vaginismus and dyspareunia. *Journal of Sexual Medicine*, *6*(6), 1617-1627.
Klein, L. K. (2018). *Pure: Inside the evangelical movement that shamed a genration of young women and how I broke free*. Touchstone.

Klein, V., Koops, T., Lange, C., & Briken, P. (2015). Sexual history of male partners of women with the diagnosis vaginismus. *Sexual and Relationship Therapy*, *30*(3), 376-384.
Kleinplatz, P. J. (1998). Sex therapy for vaginismus: A review, critique and humanistic alternative. *Journal of Humanistic Psychology*, *38*(2), 51-81.
Kleinplatz, P. J. (2003). What's new in sex therapy? From stagnation to fragmentation. *Sexual and Relationship Therapy*, *18*(1), 95-106.
Kleinplatz, P. J. (2013). Three decades of sex: Reflections on sexuality and sexology. *Canadian Journal of Human Sexuality*, *22*(1), 1-4.
Knox, S., & Burkard, A. W. (2009). Qualitative research interviews. *Psychotherapy Research*, *19*(4-5), 566-575.
Kohut, H. (1972). Thoughts on narcissism and narcissitic rage. *Psychoanalytic study of the child*, *27*(360-400).
Konkan, R., Bayrak, M., Gonullu, O. G., Senormanci, O., & Sungur, M. Z. (2012). Sexual function and satisfaction of women with vaginismus. *The Journal of Psychiatry and Neurological Sciences*, *25*(4), 305-311.
Konkan, R., Bayrak, M., Guclu, O., Senormancı, Ö., & Sungur, M. Z. (2011). Is vaginismus a specific phobia? *Bulletin of Clinical Psychopharmacology*, *21*(2), 177-178.
Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. *American Journal of Occupational Therapy*, *45*(March), 214-222.
Krueger, R. F., & Piasecki, T. M. (2002). Toward a dimensional and psychometrically-informed approach to conceptualizing psychopathology. *Behaviour Research and Therapy*, *40*, 485–499.
Kuyper, L., Wijsen, C., & de Wit, J. (2014). Distress, need for help, and positive feelings derived from participation in sex research: Findings of a population study in the Netherlands. *The Society for the Scientific Study of Sexuality*, *51*(3), 351-358.
Kvale, S., & Brinkmann, S. (2009). *Interviews: Learning the craft of qualitative research interviewing* (2 ed.). Sage.
Lahaie, M., Amsel, R., Khalif´e, S., Boyer, S. C., Faaborg-Andersen, M., & Binik, Y. M. (2015). Can fear, pain and muscle tension discriminate vaginismus from dyspareunia-provoked vestibulodynia? Implications for the new DSM-5 diagnosis of genito-pelvic pain/penetration disorder. *Archives of Sexual Behaviour*, *44*, 1537-1550.
Lahaie, M., Boyer, S. C., Rhonda, A., .R., Khalife, S., & Binik, Y. M. (2010). Vaginismus: A review of the literature on the classification/diagnosis, etiology and treatment. *Women's Health*, *6*(5), 705-719.
Lakeman, R., McAndrew, S., MacGabhann, L., Warne, T., & 2013. (2013). 'That was helpful...no one has talked to be about that before': Research participation as a therapeutic activity. *International Journal of Mental Health Nursing*, *22*, 76-84.
Lamont, J. A. (1978). Vaginismus. *American Journal of Obstetrics & Gynecology*, *131*(6), 632-636.
Laslett, B., & Rapoport, R. (1975). Collaborative interviewing and interactive research. *Journal of Marriage and the Family*, *37*, 968-977.
Laumann, E. O., A., P., & Rosen, R. C. (1999). Sexual dysfunction in the United States: Prevalence and predictors. *JAMA*, *10*(281), 537-544.
Lee, R. M. (1993). *Doing research on sensitive topics*. Sage.
Leiblum, S. R. (2000). Vaginismus: A most perplexing problem. In S. R. Leiblum & R. C. Rosen (Eds.), *Principles and practice of sex therapy* (3 ed.). Guilford Press.
Leiblum, S. R. (2007). *Principles and practice of sex therapy* (4 ed.). Guilford Press.
Leiblum, S. R., & Wiegel, M. (2002). Psychotherapeutic interventions for treating female sexual dysfunction. *World Journal of Urology*, *20*, 127-136.

Levenson, R. W., & Ruef, A. M. (1992). Empathy: A physiological substrate. *Journal of Personality and Social Psychology*, *63*(2), 234-246.
Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry*. Sage.
Linschoten, M., Weiner, L., & Avery-Clark, C. (2016). Sensate focus: A critical literature review. *Sexual and Relationship Therapy*, *31*(2), 230-247.
Litton Fox, G. (1980). The mother-adolescent daughter relationship as a sexual socialisation structure: A research review. *Family Relations*, *29*(1), 21-28.
Lodise, N. M. (2017). Female sexual dysfunction: a focus on flibanserin. *International Journal of Women's Health*, *9*, 757-767.
Lorenz, T. K. A., Rullo, J. E., & Faubion, S. S. (2016). Antidepressant-induced female sexual dysfunction. *Mayo Clinic Proceedings*, *91*(9), 1280-1286.
Lykins, A. D., Meana, M., & Minimi, J. (2011). Visual attention to erotic images in women reporting pain with intercourse. *Journal of Sex Research*, *48*(1), 43–52.
Lyons-Ruth, K., Melnick, S., Bronfman, E., Sherry, S., & Llanas, L. (2004). Hostile-helpless relational models and disorganised attachment patterns between parents and their young children: Review of research and implications for clinical work. In L. Atkinson & S. Goldberg (Eds.), *Attachment issues in psychopathology and intervention* (pp. 65-94). Lawrence Erlbaum Associates.
Lyster, S. (2012). Myth of the sisterhood. *Professional Manager*, *21*(2), 34-35.
Macey, K., Gregory, A., Nunns, D., & das Nasir, R. (2015). Women's experiences of using vaginal dilators (trainers) to treat vaginal penetration difficulties diagnosed as vaginismus: A qualitative interview study. *BMC Women's Health*, *15*(49), 1-12.
Malesevic, V. (2003). Demonic or devine? Attitudes to sex and sexuality among Galway University students. *Irish Journal of Sociology*, *12*, 107-120.
Marshania, Z. (2017). Certain sociocultural aspects of prevalence and treatment of vaginismus in Georgia. *ÆÅÍÑÊÀß ÑÅÊÑÎËÎÃÈß*, *1*(60), 71-73.
Martin, V. B., & Gynnild, A. (2011). *Grounded theory: The philosophy, method and work of Barney Glaser*. Brown Walker Press.
Maseroli, E., Scavello, I., Rastrelli, G., Linmoncin, E., Cipriani, S., Corona, G., Fambrini, M., Magini, A., Jannini, E. A., Maggi, M., & Vignozzi, L. (2018). Outcome of medical and psychosexual interventions for vaginismus: A systematic review and meta-analysis. *Journal of Sexual Medicine*, *Article in Press*, 1-13.
Masheb, R. M., Brondolo, E., & Kerns, R. D. (2002). A multidimensional, case-control study of women with self-identified chronic vulvar pain. *Pain Medicine*, *3*(September), 253-259.
Masheb, R. M., Kerns, R. D., Lozano, C., Minkin, M. J., & Richman, S. (2009). A randomised clinical trial for women with vulvodynia: Cognitive-behavioural therapy vs. supportive psychotherapy. *Pain*, *141*(1-2), 31-40.
Masters, W. H., & Johnson, V. E. (1966). *Human sexual response*. Little Brown.
Masters, W. H., & Johnson, V. E. (1970). *Human sexual inadequacy*. Little, Brown & Co.
Mayock, P., Kitching, K., & Morgan, M. (2007). *Relationships and sexuality education (RSE) in the context of social, personal and health education (SPHE): An assessment of the challenges to full implementation of the programme in post-primary schools*. Crisis Pregnancy Agency.
McAreavey, R., & Das, C. (2013). A delicate balancing act: Negotiating with gatekeepers for ethical research when researching minority communities. *International Journal of Qualitative Methods*, *12*, 113-131.
McCabe, M. P., Sharlip, I. D., Atalla, E., Balon, R., Fisher, A. D., Laumann, E., Lee, S. W., Lewis, R., & Segraves, R. T. (2016). Definitions of sexual dysfunctions in women and men: A consensus statement from the fourth International Consultation on Sexual Medicine 2015. *J Sex Med*, *13*, 135-143.

McCallin, A., Nathaniel, A. K., & Andrews, T. (2011). Learning methodology minus mentorship. In V. B. Martin & A. Gynnild (Eds.), *Grounded theory: The philosophy, method and work of Barney Glaser* (pp. 69 - 84). Brown Walker Press.

McCarthy, B., & Thestrup, M. (2008). Integrating sex therapy interventions with couple therapy. *Journal of Contemporary Psychotherapy*, *38*, 139-149.

McElvaney, R. (2019). Choosing constructivist grounded theory to explore children's experiences of disclosing sexual abuse. In F. McSweeney & D. Williams (Eds.), *Designing and conducting research in social science, health and social care*. Routledge.

McEvoy, M., McElvaney, R., & Glover, R. (2018a). Capturing the experiences of vaginsimus for Irish couples: A Dublin City University Study. *HSE Sexual Health News*, *Spring*, 9-10.

McEvoy, M., McElvaney, R., & Glover, R. (2018b). What's the impact of vaginismus on Irish relationships? *RTE Brainstorm*, *September*, Online. https://www.rte.ie/brainstorm/2018/0903/991262-whats-the-impact-of-vaginismus-on-irish-relationships/

McGhee, G., Marland, G. R., & Atkinson, J. (2008). Grounded theory research: Literature reviewing and reflexivity. *Journal of Advanced Nursing*, *60*(3), 334-342.

McGuire, H., & Hawton, K. K. E. (2009). Interventions for vaginismus (review). *The Cochrane LIbrary*, *2*, 1-15.

McNeely, C., Shew, M. L., Beuhring, T., Sieving, R., Miller, B. C., & Blum, R. W. M. (2002). Mothers' influence on the timing of first sex among 14- and 15- year olds. *Journal of Adolescent Health*, *31*, 256-265.

Meana, M. (2009). Painful intercourse: Dyspareunia and vaginismus. *Journal of Family Psychotherapy*, *20*(2-3), 198-220.

Meana, M., Binik, Y. M., & Thaler, L. (2008). Sexual Dysfunction. In J. Hunsley & E. J. Mash (Eds.), *A guide to assessments that work*. Oxford University Press.

Meana, M., Fertel, E., & Maykut, C. (2017). Treating genital pain associated with sexual intercourse. In Z. D. Peterson (Ed.), *The Wiley Handbook of Sex Therapy*. John Wiley & Sons.

Meana, M., Maykut, C., & Fertel, E. (2015). Painful intercourse: Genito-pelvic pain/penetration disorder. In K. M. Hertlein, G. T. Weeks, & N. Gambescia (Eds.), *Systemic sex therapy* (2nd ed., pp. 191-210). Routledge.

Melles, R. J., Dewitte, M. D., ter Kuile, M. M., Peters, M. M. L., & de Jong, P. J. (2016). Attentional bias for pain and sex, and automatic appraisals of sexual penetration: Differential patterns in dyspareunia vs vaginismus? *Journal of Sexual Medicine*, *13*, 1255-1262.

Melles, R. J., Ter Kuile, M., Dewitte, M., Van Lankveld, J. J. D. M., Brauer, M., & De Jong, P. J. (2013). Automatic and deliberate affective associations with sexual stimuli in women with lifelong vaginismus before and after therapist-aided exposure treatment. *Journal of Sexual Medicine*, *11*(3), 786–799.

Melnik, T., Hawton, K., & McGuire, H. (2012). Interventions for vaginismus (review). *The Cochrane Database of Systematic Reviews*(12), 1-37.

Menage, J., & Counselling, D. (1993). Post-traumatic stress disorder in women who have undergone obstetric and/or gynecological procedures: A consecutive series of 30 cases of PTSD. *Journal of Reproductive and Infant Psychology*, *11*, 221-228.

Mercer, C. H., Fenton, K. A., Johnson, A. M., Wellings, K., Macdowall, W., McManus, S., Nanchahal, K., & Erens, B. (2003). Sexual function problems and help seeking behaviour in Britain: National probability sample survey. *British Medical Journal*, *327*, 426-427.

Mernissi, F. (1985). *Beyond the veil: Male-female dynamics in a modern Muslim society*. Al Saqi.

Meston, C. M., Rellini, A. H., & Heiman, J. R. (2006). Women's history of sexual abuse, their sexuality, and sexual self-schemas. *Journal of Consulting and Clinical Psychology*, *74*(2), 229–236.

Meyer-Williams, L. (1994). Recall of childhood trauma: A prospective study of women's memories of child sexual abuse. *Journal of Consulting and Clinical Psychology*, *62*(6), 1167-1176.

Mikulincer, M., Florian, V., Cowman, P. A., & Cowan, C. P. (2002). Attachment security in couple relationships: A systemic model and its imlications for family dynamics. *Family Processes*, *41*(3), 405-434.

Miles, J., & Gilbert, P. (2005). *A handbook of research methods for clinical and health psychology*. Oxford University Press.

Miller, A. (1979). The drama of the gifted child, and the psycho-analyst's narcissistic disturbance. *International Journal of Psychoanalysis*, *60*, 47-58.

Miller, T., Boulton, M., & 2007. (2007). Changing constructions of informed consent: Qualitative research and complex social worlds. *Social Science and Medicine*, *65*(11), 2199-2211.

Mitchell, K. R., Geary, R., Graham, C. A., Datta, J., Wellings, K., Sonnenberg, P., Filed, N., Nunns, D., Bancroft, J., Jones, K. G., Johnson, A. M., & Mercer, C. H. (2017). Painful sex (dyspareunia) in women: Prevalence and associated factors in a British population probability survey. *International Journal of Obstetrics and Gynaecology*, *124*, 1689-1697.

Mitchell, K. R., Mercer, C. H., Ploubidis, G. B., Jones, K. G., Datta, J., Filed, N., Cospas, A. J., Tanton, C., Erens, B., Sonnenberg, P., Clifton, S., Macdowall, W., Phelps, A., Johnson, A. M., & Wellings, K. (2013). Sexual functioning in Britain: Findings from the third National Survey of Sexual Attitudes and LIfestyles (Natsal-3). *The Lancet*, *382*(9907), 1817-1829.

Moncrieff, S. (2019, 28 January 2019). New studies on vaginismus In *Moncrieff with Sean Moncrieff [Podcast] Newstalk*. https://www.newstalk.com/podcast/new-studies-on-vaginismus

Morgan, D., Dhruva, S. S., Wright, S. M., & Korenstein, D. (2015). Update on medical practices that should be questioned in 2015. *JAMA International Medicine*, *175*(12), 1-5.

Mortari, L. (2015). Reflectivity in research practice: An overview of different perspectives. *International Journal of Qualitative Methods*, *14*(5), 1-9.

Mousavi-Nasab, M., & Farnoosh, Z. (2003). Management of vaginismus with cognitive – behavioural therapy, self-finger approach: A study of 70 cases. *Iranian Journal of Medical Sciences*, *28*(2), 69-71.

Moynihan, M. (2019, 20 February). No Go Area. *Irish Country Magazine*, *March*, 70-73.

Murray, M. (2008). Narrative psychology. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods, 2nd Edition* (pp. 111-132). Sage.

Nathaniel, A. K. (2011). An integrated philosophical framework that fits grounded theory. In V. B. Martin & A. Gynnild (Eds.), *Grounded theory: The philosophy, method and work of Barney Glaser* (pp. 187 - 200). Brown Walker Press.

Newell, J. M., & MacNeil, G. A. (2010). Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue: A review of theoretical terms, risk factors and preventive methods for clinicians and researchers. *Best Practice in Mental Health*, *6*(2), 57-68.

Newman, E., & Kaloupek, D. (2009). Overview of resarch addressing ethical dimensions of participation in traumatic stress studies: Autonomy and beneficence. *Journal of Traumatic Stress*, *22*(6), 595-602.
Ng, M. L. (1988). Sex therapy for the Chinese in Hong Kong. *Sexual and Marital Therapy*, *3*(2), 245-252.
Ng, M. L. (2001). Female sexual dysfunction. *Journal of Paediatrics, Obstetrics and Gynaecology (Hong Kong Edition)*, *27*(3), 45-48.
Ng, M. L. (2010). *The meaning of sexual intercourse: Personal accounts of Hong Kong Chinese married women who have experienced difficulty in vaginal penetrative sex* [PhD., University of Hong Kong].
Nga, A. N. H. (2004). Making sense of the pain of sexual intercourse: Personal accounts of Hong Kong Chinese married Women who have experienced difficulty in vaginal penetrative sex. *Sexual and Marital Therapy*, *14*, 9-13.
Nickerson, A. B., & Nagle, R. J. (2005). Parent and peer attachment in late childhood and early adolescence. *The Journal of Early Adolescence*, *25*(2), 223-249.
Nolte, T., Guiney, J., Fonagy, P., Mayes, L. C., & Luyten, P. (2011). Interpersonal stress regulation and the development of anxiety disorders: An attachment-based developmental framework. *Behavioural Neuroscience*, *5*(55), 1-21.
Oberg, K., Fugl-Meyer, A. R., & Fugl-Meyer, K. S. (2004). On categorization and quantification of women's sexual dysfunctions: an epidemiological approach. *Int J Impot Res*, *16*(3), 261-269.
Ogden, J., & Ward, E. (1995). Help-seeking behaviour in sufferers of vaginismus. *Journal of Sexual and Maritial Thearpy*, *10*, 23-30.
Ogden, J., & Ward, E. (2014). Extraordinary sex therapy introduction: Are we asking questions that help our clients? *Sexual and Relationship Therapy*, *29*(1), 1-7.
Oireachtas. (2019). *Joint Committee on Education and Skills Report on Relationships and Sexuality Education*. Houses of the Oireachtas.
OKeefe, D. (2018a, 29 August). Vaginismus: The second most prevalent female sexual difficulty presenting at clinics. *Independent* Online. https://www.independent.ie/life/health-wellbeing/health-features/vaginismus-the-second-most-prevalent-female-sexual-difficulty-presenting-at-clinics-37263305.html
OKeefe, D. (2018b, 29 August). We need to talk about vaginsimus. *Herald Health Supplement*, 26-27.
Oksuz, E., & Malhan, S. (2006). Prevalence and risk factors for female sexual dysfunction in Turkish Women. *Journal of Urology*, *175*, 654-658.
Oliver, D. B., Serovich, J. M., & Mason, T. L. (2005). Constraints and opportunities with interview transcription: Towards reflection in qualitative research. *Social Forces*, *84*(2), 1273-1289.
Oniz, A., Keskinoglu, P., & Bezircioglu, I. (2007). The prevalence and causes of sexual problems among premenopausal Turkish women. *Journal of Sexual Medicine*, *4*(6), 1575-1581.
Orbach, S. (2009). Seperated attachments and sexual aliveness. In C. Culow & P. Fonagy (Eds.), *Sex, attachment and couple psychotherapy: A psychoanalytic perspective*. Karnac.
OSullivan, K. (1979). Observations on vaginismus in Irish women. *Archives of General Psychiatry*, *36*(7), 824-826.
Ozcan, O., Elbozan Cumurcu, B., Karlidag, R., Unal, S., Aktan Mutlu, E., & Kartalci, S. (2015). Attachment styles in women with vaginismus. *Anatolian Journal of Psychiatry*, *16*(1), 37-43.

Ozdemir, O., Simsek, F., Ozkardes, S., Incesu, C., & Karakoc, B. (2008). The unconsummated marriage: Its frequency and clinical characteristics in a sexual dysfunction clinic. *Journal of Sex and Marital Therapy*, *34*(3), 268-279.

Pacey, S. L. (2018). *An investigation into psychodynamic couple psychotherapists' theories of sensate focus in clinical practice* [PhD., University of East London Cass School of Education & Communities and Tavistock Centre for Couple Relationships]. London.

Pacik, P. T. (2011). Vaginismus: Review of current concepts and treatment using botox injections, bupivacaine injections and progressive dilation with the patient under anaesthesia. *Aesthetic Plastic Surgery*, *35*, 1160-1164.

Pacik, P. T. (2014a). Understanding and treating vaginismus: A multimodal approach. *International Urogynecology Journal*, *25*, 1613-1620.

Pacik, P. T. (2014b). Vaginismus: Another ignored problem. *Sexuality & Culture*, *18*, 737–738.

Pacik, P. T., Babb, C. R., Polio, A., Nelson, C. E., Goekeler, C. E., & Holmes, L. N. (2018). Case series: Redefining severe grade 5 vaginimsus. *Sexual Medicine*, *Article in Press*, 1-9.

Parameshwawran, S., & Chandra, P. S. (2019). The new avatar of female sexual dysfunction in ICD-11 - will it herald a better future? *Journal of Psychosexual Health*, *1*(12), 111-113.

Parera, N., & Suris, J. C. (2004). Having a good relationship with their mother: A protective factor against sexual risk behaivour among adolescent females? *Journal of Paediatrics & Adolescent Gynaecology*, *17*(267-271).

Pearlman, L. A., & Courtois, C. A. (2005). Clinical applications of the attachment framework: Relational treatment of complex trauma. *Journal of Traumatic Stress*, *18*(5), 449-459.

Pereira, V. M., Arias-Carrion, O., Machado, S., Nardi, A. E., & Cardoso Silva, A. (2013). Sex therapy for female sexual dysfunction. *International Archives of Medicine*, *6*, 37-45.

Perez, S., & Binik, Y. M. (2016). Vaginismus: "Gone" but not forgotten. *Psychiatric Times*, *33*(7), Online.

Praharaj, S. K., Verma, P., & Arora, M. (2006). Topical lignocaine for vaginismus: a case report. *Int J Impot Res*, *18*(6), 568-569.

PSI. (2011). *Code of professional ethics*. PSI.

Pukall, C. F. (2009). Sex therapy is special because it deals with sex. *Archives of Sexual Behaviour*, *38*(6), 1039-1040.

Reissing, E. D. (2012). Consultation and treatment history and causal attributions in an online sample of women with lifelong and acquired vaginismus. *Journal of Sexual Medicine*, *9*, 251-258.

Reissing, E. D., Armstrong, H. L., & Allen, C. (2013). Pelvic floor physical therapy for lifelong vaginismus: A retrospective chart review and interview study. *Journal of Sex and Marital Therapy*, *39*, 306-320.

Reissing, E. D., Binik, Y. M., Khalife, S., Cohen, D., & Amsel, R. (2003). Aetiological correlates of vaginismus: Sexual and physical abuse, sexual knowledge, sexual self-schema and relationship adjustment. *Journal of Sex and Marital Therapy*, *29*, 47-59.

Reissing, E. D., Binik, Y. M., Khalife, S., Cohen, D., & Amsel, R. (2004). Vaginal spasm, pain, and behaviour: An empirical investigation of the diagnosis of vaginismus. *Archives of Sexual Behaviour*, *33*(1), 5-17.

Reissing, E. D., Borg, C., Spoelstra, S. K., ter Kuile, M. M., Both, S., de Jong, P. J., Van Lankveld, J. J. D. M., Melles, R. J., Weijenborg, P. T. M., & Weijmar Schultz, W. C. M. (2014). "Throwing the baby out with the bathwater": The demise of vaginismus in favour of genito-pelvic pain/penetration disorder. *Archives of Sexual Behavior,*, *43*, 1209-1213.

Ribner, D. S., & Rosenbaum, T. Y. (2005). Evaluation and treatment of unconsummated marriages among orthodox Jewish couples. *Journal of Sex and Marital Therapy*, *31*, 341-353.

Rink, E., Tricker, R., & Harvey, S. M. (2007). Onset of sexual intercourse among female adolescents: The influence of perceptions, depression and ecological factors. *Journal of Adolescent Health*, *41*, 398-406.

Rogan, M. F. (2017). *Sex for simple humans: Sex throughout your life*. Independently Published.

Rolston, B., Schubotz, D., & Simpson, A. (2006). Sex education in Northern Ireland schools: A critical evaluation. *Sex Education: Sexuality, Society and Learning*, *5*(3), 217-234.

Rosen, N. A., Bergeron, S., Glowacka, M., Delisle, I., & Baxter, M. L. (2012). Harmful of helpful: Perceived solicitous and facilitative partner responses are differentially associated with pain and sexual satisfaction in women with provoked vestibulodynia. *Journal of Sexual Medicine*, *9*(9), 2351-2360.

Rosen, N. O., Bergeron, S., Sadikaj, G., Glowacka, M., Delisle, I., & Baxter, M. L. (2014). Impact of male partner responses on sexual function in women with vulvodynia and their partners: A dyadic daily experience study. *Health Psychology*, *33*(8), 823-831.

Rosen, R. C., & Leiblum, S. R. (1995). Treatment of sexual disorders in the 1990s: An integrated approach. *Journal of Consulting and Clinical Psychology*, *63*(6), 877-890.

Rosenbaum, T. (2011). Addressing anxiety in vivo in physiotherapy treatment of women with severe vaginismus: a clinical approach. *Journal of Sex and Marital Therapy*, *37*(2), 89-93.

Rosenbaum, T. (2018). Limits of pelvic floor physical therapy in the treatment of GPPD. *Current Sexual Health Reports*, *Author's Personal Copy*.

Rosenbaum, T., Aloni, R., & Heruti, R. (2013). Surrogate partner therapy: Ethical considerations in sexual medicine. *Journal of Sexual Medicine*, *11*(2), 321-329.

Rosenbaum, T. Y. (2005). Physiotherapy treatment of sexual pain disorders. *Journal of Sex and Marital Therapy*, *31*(4), 329-340.

Rosenbaum, T. Y. (2013). An integrated mindfulness-based approach to the treatment of women with sexual pain and anxiety: Promoting autonomy and mind/body connection. *Sexual and Relationship Therapy*, *28*(1-2), 20-28.

Rosenbaum, T. Y., & Owens, A. (2008). The role of pelvic floor physical therapy in the treatment of pelvic and genital pain-related sexual dysfunction. *Journal of Sexual Medicine*, *5*, 513-523.

Rosenbaum, T. Y., & Padoa, A. (2012). Managing pregnancy and delivery in women with sexual pain disorders. *Journal of Sexual Medicine*, *9*(7), 1726-1735.

Rowlands, B. H. (2005). Grounded in practice: Using interpretive research to build theory. *The Electronic Journal of Business Research Methodology*, *3*(1), 81-92.

Roy, J. (2002). A survey of Relate psychosexual therapy clients, January to March 2002. *Sexual and Relationship Therapy*, *19*(2), 155-166.

Ruhl, H., Dolan, E. A., & Buhrmester, D. (2015). Adolescent attachment trajectories with mothers and fathers: The importance of parent-child relationship experiences and gender. *Journal of Research on Adolescence*, *25*(3), 427-442.

Rutter, M., & Sroufe, L. A. (2000). Developmentl psychopathology: Concepts and challenges. *Development and Psychopathology*, *12*, 265-296.

Safarinejad, M. R. (2006). Female sexual dysfunction in a population-based study in Iran: Prevalence and associated risk factors. *Int J Impot Res*, *18*, 382-395.

Salu, Y. (2013). The role of the amygdala in the development of sexual arousal. *Electronic Journal of Human Sexuality*, *16*.

Sampson, H., Bloor, M., & Fincham, B. (2008). A price worth paying? Considering the 'cost' of reflexive research methods and the influence of feminist ways of 'doing'. *Sociology*, *42*(5), 919-933.
Sanchez Bravo, C., Jorge Carreno Melendez, J. C., Corres Ayala, N. P., & Taracena-Ruiz, B. E. (2010). Perfiles e indicadores psicológicos relacionados con la dispareunia y el vaginismo: Estudio cualitativo. Segunda parte [Psychological profiles and indicators related to dyspareunia and vaginismus: Qualitative study. Second part]. *Salud Mental*, *33*(5), 437-449.
Sbarra, D. A., & Hazan, C. (2008). Coregulation, dysregulation self-regulation: An integrative analysis and empirical agenda for understanding adult attachment, separation, loss and recovery. *Journal of Personality and Social Psychology Review*, *12*, 141-167.
Schimmenti, A., & Bifulco, A. (2013). Linking lack of care in childhood to anxiety disorders in emerging adulthood: The role of attachment styles. *Child and Adolescent Mental Health*, *20*(1), 41-48.
Schon, D. A. (1987). *Educating the Reflective Practitioner*. Jossey-Bass.
Schore, A. N. (2000). Attachment and the regulation of the right brain. *Attachment and Human Development*, *2*(1), 23-47.
Schore, A. N. (2005). Attachment, affect regulation, and the developing right brain. *Paediatrics in Review*, *26*, 204-211.
Schore, J. R., & Schore, A. N. (2008). Modern attachment theory: The central role of affect regulation in develpment and treatment. *Clinical Social Work Journal*, *36*, 9-20.
Schover, L. R., & Leiblum, S. R. (1994). Commentary: The stagnation of sex therapy. *Journal of Psychology and Human Sexuality*, *6*(3), 5-30.
Segraves, R. T. (2001). Historical and iInternational context of nosology of female sexual disorders. *Journal of Sex and Marital Therapy*, *27*, 205-207.
Shaw, J. (2001). Commentary: Another procrustean bed for female sexual functioning. *Journal of Sex and Marital Therapy*, *27*, 211-214.
Shokrollahi, P., Mirmohamadi, M., Mehrabi, F., & Babaei, G. (1999). Prevalence of sexual dysfunction in women seeking services at family planning centers in Tehran. *Journal of Sex and Marital Therapy*, *25*, 211-215.
Showalter, E. (1987). *The female malady: Women, madness and English culture 1830-1980*. Virago Press.
Shtarkshall, R. A., Santelli, J. S., & Hirsch, J. S. (2007). Sex education and sex socialisation: Roles for educators and parents. *Perspectives on Sexual and Reproductive Health*, *39*(2), 116-119.
Silverstein, J. L. (1989). Origins of psychogenic vaginismus. *Psychotherapy and Psychosomatics*, *52*(4), 197-204.
Simonelli, C., Stefano, E., Filippo, P., & Roberta, R. (2014). Female sexual pain disorders: dysparuenia and vaginismus. *Current Opinion in Psychiatry*, *27*, 406-412.
Singer-Kaplan, H. (1974). *The new sex therapy: Active treatment of sexual dysfunction*. Penguin.
Singer-Kaplan, H. (1983). *The evaluation of sexual disorders: Psychological and medical aspects*. Taylor and Francis.
Smith, J. A. (2008). *Qualitiatve psychology: A practical guide to research methods* (2 ed.). Sage.
Smith, J. A., & Osborn, M. (2008). Interpretative phenomenological anallysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (2 ed., pp. 53-80). Sage.
Soeter, M., & Kindt, M. (2012). Erasing fear for an imagined threat event. *Psychoneuroendocrinology*, *37*, 1769-1779.

Spiegel, J., Severino, S. K., & Morrison, N. K. (2000). The role of attachment functions in psychotherapy. *The Journal of Psychotherapy Practice and Research*, *9*(1), 25-32.
Spoelstra, S. K. (2017). *The genito-pelvic pain/penetration disorder paradigm and beyond: Theoretical and empirical perspectives* [PhD., University of Groningen]. Groningen.
Sroufe, L. A. (2005). Attachment and development: A prospective, longitudinal study from birth to adulthood. *Attachment and Human Development*, *7*(4), 349 – 367.
Strauss, A. L. (1993). *Continual permutations of action*. Aldine Transaction.
Strauss, A. L., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory.* Sage.
Stuart, S., & Noyes, R. (1999). Attachment and interpersonal communication in somatisation. *Psychosomatics*, *1*, 34-43.
Sudman, S., & Kalton, G. (1986). New developments in the sampling of special populations. *Annual Review of Sociology*, *12*, 401-429.
Taylor, B., & Davis, S. (2006). Using the extended PLISSIT model to address sexuality in primary care. *Nursing Standard*, *21*(11), 35-41.
ter Kuile, M., & Reissing, E. D. (2014). Lifelong vaginismus. In Y. M. Binik & K. S. K. Hall (Eds.), *Principles and Practice of Sex Therapy* (5 ed., pp. 177-192). The Guilford Press.
ter Kuile, M. M., Bulte, I., Weijenborg, T. M., Beekman, A., Melles, R., & Onghena, P. (2009). Therapist-aided exposure for women with lifelong vaginismus: A replicated single-case design. *Journal of Consulting and Clinical Psychology*, *77*(1), 149-159.
ter Kuile, M. M., van Lankveld, J. J. D. M., De Groot, E., Melles, R., Neffs, J., & Zandbergen, M. (2007). Cognitive-behavioural therapy for women with lifelong vaginismus: Process and prognostic factors. *Behaviour Research and Therapy*, *45*, 359-373.
ter Kuile, M. M., & Weijenborg, P. T. M. (2006). A cognitive-behavioural group progam for women with vulvar vestibulitis syndrome (VVS): Factors associated with treatment success. *Journal of Sex and Marital Therapy*, *32*(3), 199-213.
Thériault, J. (2003). Sexual and non-sexual intimacy in romantic relationships during late adolescence: The role of the mother-daughter relationship *Electronic Journal of Human Sexuality*, *6*.
Thomson, S. B. (2011). Sample size and grounded theory. *Journal of Administration and Governance*, *5*(1), 45-52.
Tiefer, L. (2000). Sexology and the pharmaceutical industry: The threat of co-optation. *Journal of Sex Research*, *37*(3), 273-283.
Tiefer, L. (2001a). Arriving at a "new view" of women's sexual problems: Background theory and activism. In E. Kaschak & L. Tiefer (Eds.), *A new view of women's sexual problems* (pp. 63-98). Routledge.
Tiefer, L. (2001b). A new view of women's sexual problems: Why new? Why now? *Journal of Sex Research*, *38*, 89-96.
Timm, T. M. (2009). "Do I really have to talk about sex?" Encouraging beginning therapists to integrate sexuality into couples therapy. *Journal of Couple and Relationship Therapy*, *8*(1), 15-33.
Tolich, M. (2004). Internal confidentiality: When confidentiality assurances fail relational informants. *Qualitative Sociology*, *27*(1), 101-106.
Trauth, E. M. (2001). *Qualitative resarch in IS: Issues and trends*. Idea Group Publishing.
Troiden, R. R. (1987). Walking the line: The personal and professional risks of sex education and research. *Teaching Sociology*, *15*, 241-249.
Tsui, L., & Nicoladis, E. (2004). Losing it: Similarities and differences in first intercourse experiences of men and women. *The Canadian Journal of Human Sexuality*, *13*(2), 95-106.

Tugrul, C., & Kabakci, E. (1997). Vaginismus and its correlates. *Sexual and Marital Therapy*, *12*(1), 23-34.

Tulla, M. E., Dunn, M. E., Antilus, R., & Muneyyirci-Delale, O. (2006). Case report: Vaginismus and failed in vitro fertilization. *Sexual and Relationship Therapy*, *21*(4), 439-443.

Turner, D. W. (2010). Qualitative interview design: A practical guide for novice investigators. *The Qualitative Report*, *15*(3), 754-760.

Tutte, J. C. (2004). The concept of psychical trauma: A bridge in interdisciplinary space. *International Journal of Psychoanalysis*, *85*, 897-921.

Tuval-Mashiach, R. (2017). Raising the curtain: The importance of transparency in qualitative research. *Qualitative Psychology*, *4*(2), 126-138.

Tyrer, P. (2014). A comparison of DSM and ICD classifications of mental disorder. *Advances in Psychiatric Treatment*, *20*, 280-285.

Ussher, J. M., & Baker, C. D. (1993). *Psychological perspectives on sexual problems*. Routlege.

Vahdaninia, M., Montazeri, A., & Goshtasebi, A. (2009). Help-seeking behaviours for female sexual dysfunction: A cross secitonal study from Iran. *BMC Women's Health*, *9*(3), 1-7.

Vaillancourt-Morel, M.-P., Godbout, N., Labadie, C., Runtz, M., Lussier, Y., & Sabourin, S. (2014). Avoidant and compulsive sexual behaviors in male and female survivors of childhood sexual abuse. *Child abuse & neglect*. https://doi.org/10.1016/j.chiabu.2014.10.024

Valandra, V. (2012). Reflexivity and professional use of self in research: A doctoral student's journey. *Journal of Ethnographic & Qualitative Research*, *6*, 204-220.

Valins, L. (1988). *Vaginismus: Understanding & overcoming the blocks to intercourse.* Ashgrove Press Ltd.

van der Velde, J., & Everaerd, W. (2001). The relationship between involuntary pelvic floor muscle activity, muscle awareness and experienced threat in women with and without vaginismus. *Behaviour Research and Therapy*, *39*, 395–408.

van Lankveld, J. (2009). Self-help therapies for sexual dysfunction. *The Journal of Sex Research*, *46*(2), 143-155.

van Lankveld, J. D. M., Granot, M., Weijmar-Schultz, W., Binik, Y. M., Wesselmann, U., Pukall, C. F., Bohm-Starke, N., & Achtrari, C. (2010). Women's sexual pain disorders. *Journal of Sexual Medicine*, *7*, 615–631.

Van Lankveld, J. J. D. M., Brewaeys, A. M. A., ter Kuile, M. M., & Weijenborg, P. T. M. (1994). Difficulties in the differential diagnosis of vaginismus, dyspareunia and mixed sexual pain disorder. *Journal of Psychosomatic Obstetrics & Gyanecology*, *16*(4), 201-209.

Van Lankveld, J. J. D. M., Everaerd, W., & Grotjohann, Y. (2001). Cognitive-behavioural bibliotherapy for sexual dysfunctions in heterosexual couples: A randomised waiting-list controlled clinical trial in the Netherlands. *The Journal of Sex Research*, *38*(1), 51-67.

van Overveld, M., de Jong, P. J., Peters, M. L., van Lankveld, J., Melles, R., & ter Kuile, M. M. (2013). The sexual disgust questionnaire: A psychometric study and a first exploration in patients with sexual dysfunctions. *Journal of Sexual Medicine*, *10*(2), 396-407.

van Teijlingen, E. (2001). The importance of conducting and reporting pilot studies: The example of the Scottish Births Survey. *Journal of Advanced Nursing*, *34*(3), 289-295.

Vegunta, S., Kling, J. M., & Faubion, S. S. (2016). Sexual health matters: Management of female sexual dysfunction. *Journal of Women's Health*, *25*(9).

Velayati, A., Sadatmahalleh, S. J., Ziaei, S., & Kazemnejad, A. (2019). Can Botox offer help women with vaginismus? A systematic review and meta-analysis. *International Journal of Sexual Health*, *31*(3), 233-243.
Ventegodt, S. (1998). Sex and the quality of life in Denmark. *Archives of Sexual Behaviour*, *27*, 295-307.
Walton, I. (2016). Ethical Research. *Midwifery Matters*, *151*(Winter), 18-20.
Ward, E., & Ogden, J. (1994). Experiencing vaginismus: Sufferers' beliefs about causes and effects. *Sexual and Marital Therapy*, *9*(1), 33-45.
Watts, G., & Nettle, D. (2009). The role of anxiety in vaginismus: A case-control study. *Journal of Sexual Medicine*, *7*(1 Pt 1), 143-148.
Webber, V., & Brunger, F. (2018). Assessing risk to researchers: Using the case of sexuality research to inform research ethics board guidelines. *Qualitative Social Research*, *19*(3), 2.
Weijmar-Schultz, W., Basson, R., Binik, Y. M., Eschenbach, D., Wesselmann, U., & Van Lankveld, J. (2005). Women's sexual pain and its management. *Journal of Sexual Medicine*, *2*, 301-316.
Weiner, L., & Avery-Clark, C. (2014). Sensate focus: Clarifying the Masters and Johnson's model. *Sexual and Relationship Therapy*, *29*(3), 307-319.
WHO. (1992). *The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines*. World Health Organisation.
WHO. (2020). *International statistical classification of diseases and related health problems (11th edition)*. World Health Organisation.
Wijma, B., Engman, M., & Klaas, W. (2007). A model for critical review of literature - with vaginismus as an example. *Journal of Psychosomatic Obstetrics & Gyanecology*, *28*(1), 21-36.
Wilentz, G. (2016). The importance of European standards and human rights-based approach in strenghening the implementation of sexuality education in Ireland. *Sex Education*, *4*, 439-445.
Wiles, R., Charles, V., Crow, G., & Heath, S. (2006). Resarching researchers: Lessons for research ethics. *Qualitative Research*, *6*, 283-299.
Williams, M., & May, T. (1996). *Introduction to the philosophy of social research*. UCL Press Ltd.
Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Oxford University Press.
Willig, C. (2008). Discourse analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (2 ed., pp. 160-185). Sage.
Willig, C. (2012). Perspectives on the epistemological bases for qualitative research. In H. Cooper (Ed.), *APA handbook of research methods in psychology* (Vol. 1, pp. 5-21). APA.
Willig, C., & Stainton-Rogers, W. (2008). *The Sage handbook of qualitative research in psychology*. Sage.
Wilson, E. K., Dalberth, H. P., Koo, H. P., & Gard, J. C. (2010). Parents' perspectives on talking to preteenage children about sex. *Perspectives on Sexual and Reproductive Health*, *42*(1), 56-63.
Wincze, J. P. (2009). *Enhancing sexuality: A problem solving approach to treating sexual dysfunction: therapist guide* (2 ed.). Oxford University Press.
Winnicott, D. W. (1965). *The maturational processes and the facilitating environment: Studies in the theory of emotional development*. The Hogarth Press & the Institute of Psycho-Analysis.
Woo, J. S., & Brotto, L. A. (2008). Age of first sexual intercourse and acculturation: Effects on adult sexual responding. *Journal of Sexual Medicine*, *5*(3), 571-582.

Wylie, K., & Mimoun, S. (2009). Sexual response models in women. *Maturitas*, *63*(2), 112-115.

Yasan, A., & Akdeniz, N. (2009). Treatment of lifelong vaginismus in traditional Islamic couples: A prospective study. *Journal of Sexual Medicine*, *6*(4), 1054-1061.

Yasan, A., Essizoglu, A., & Yildirim, E. A. (2009a). Inappropriate treatment of a woman with vaginismus and social and psychiatric consequences in a traditional culture. *Sexual and Relationship Therapy*, *24*(3-4), 286-291.

Yasan, A., & Gurgen, F. (2008). Marital satisfaction, sexual problems, and the possible difficulties on sex therapy in traditional Islamic culture. *Journal of Sex and Marital Therapy*, *35*(1), 68-75.

Yasan, A., Tamam, L., Ozkan, M., & Gurgen, F. (2009b). Premarital sexual attitudes and experiences in university students. *Anatolian Journal of Clinical Investigation*, *3*(3), 174-184.

Yildirim, E. A., Cavas, S., Hacioglu, M., & Yanik, M. (2009). Psychiatric comorbidity in females with vaginismus. *European Neuropsychopharmacology*, *19*, 700-701.

Zargooshi, J. (2008). Male sexual dysfunction in unconsummated marriage: long-term outcome in 417 patients. *Journal of Sexual Medicine*, *5*(12), 2895-2903.

Zielinski, R. E. (2013). Assessment of women’s sexual health using a holistic, patient-centered approach. *Journal of Midwifery and Women's Health*, *58*(3), 321-327.

Appendix A: Recruitment Poster for Agencies

Understanding Vaginismus in the Irish Context: A Qualitative Study

Have you experienced vaginismus in your relationship?
Would you be willing to share your story as part of a research study?

Why might you want to get involved?

At present, there is little information about vaginismus in Ireland from the point of view of both partners. The research study, therefore, seeks to develop a theory of vaginismus from the perspective of Irish couples. It is hoped that this new understanding of vaginismus from their perspective will have a beneficial impact on the future understanding and sensitive treatment of all couples by health care professionals.

Who will participate in the research?

Couples who grew up in Ireland, who are over the age of eighteen, and who have experienced vaginismus in their relationship will be invited to share these experiences as part of the study. Health care providers will also be asked to share their experience of working with couples.

What is the research about?

This study is interested in the experience of vaginismus from the perspective of Irish couples. It also seeks to find out what couples and health professionals think about the availability and quality of treatment for vaginismus in Ireland. Couples and health professionals will be asked to take part in an interview about their understanding of vaginismus and their assessment of the current provision of care in Ireland.

What will participation involve?

If you decide to participate in the study, you will be interviewed with your partner about the experience of vaginismus in your relationship. Each interview should take about one hour to ninety minutes. The interviews will be conducted at a mutually degreed location and time. All the interviews will be audio-taped.

If you would like to take part in this study or require additional information, please contact:

Maria McEvoy, Principal Investigator

Phone: +353 (0)87 401 9690
Email: maria.mcevoy26@mail.dcu.ie
Twitter: https://twitter.com/irishVaginismus
Linked in: https://www.linkedin.com/in/maria-mcevoy-aa91a5134
Facebook: https://www.facebook.com/groups/146160606150136/

Appendix B: Information Sheet for Professionals

DUBLIN CITY UNIVERSITY

SCHOOL OF NURSING AND HUMAN SCIENCES
INFORMATION LEAFLET FOR A RESEARCH PROJECT

Title of study: Understanding Vaginismus in the Irish Context: A Qualitative Study.

Supervisors: Dr. Rosaleen McElvaney and Dr. Rita Glover

Principal Investigator: Maria McEvoy
School of Nursing and Human Sciences
Dublin City University, Collins Avenue, Dublin 9

Email: maria.mcevoy26@mail.dcu.ie

Phone: 087 4019690

Introduction

This leaflet is designed to give you some information about a research project on the experience of couples with vaginismus that I am conducting as part of my PhD studies. Participation in the project is voluntary and it is entirely up to you whether you wish to take part. This study has been approved by the DCU Ethics Committee.

Who will participate in the research?

Couples who grew up in Ireland, who are over the age of eighteen, and who have experienced vaginismus in their relationship will be invited to share these experiences as part of the study. In addition, health care providers are being asked to share their experience of working with couples.

What is the research about?

This study is interested in the experience of vaginismus from the perspective of Irish couples. It also seeks to find out what couples and health professionals think about the availability and quality of treatment for vaginismus in Ireland. Couples and health professionals will be asked to take part in an interview about their understanding of vaginismus and their assessment of the current provision of care in Ireland. The results of the study will be available at DCU library in the form of a PhD thesis and also as published material.

What will participation involve?

If you decide to participate in the study, you will be asked to take part in an interview about your experience of working with couples with vaginismus and a description of the treatments that your service provides. All the interviews will be audio-taped. This interview should take about an hour.

Why might you want to get involved?

The research study seeks to develop a theory of vaginismus from the perspective of couples and health care professionals who are treating them. This study seeks to build a biopsychosocial theory that looks at vaginismus from multiple perspectives in order to have a greater understanding of the condition, how it impacts on the lives of Irish couples and people's experiences of getting help.

Are there any risks?

I do not foresee any risks to health professionals who agree to participate. You will not be asked to disclose the identities of your clients and neither you nor your organization will be identified in the research study. You are free to withdraw from the study at any time.

What about confidentiality?

Your anonymity and the confidentiality will be protected but all information can be subject to subpoena by the Data Protection Act (1998) and the Freedom of Information Act (2000). The only people with access to the information from the interviews will be the researcher herself and her supervisors. The transcripts of the interviews will be stored securely in the form of electronic transcribed material on an encrypted password protected desktop computer. Some direct quotations from the interviews will be used for illustrative purposes but no identifying information will remain linked to the data, only pseudonyms will be used in publications and in the thesis.

How do I get involved?

If you are interested in taking part, please contact Maria McEvoy at the following email address: maria.mcevoy26@mail.dcu.ie or alternatively, write to Maria McEvoy at the School of Nursing and Human Sciences, Dublin City University, Collins Avenue, Dublin 9 or phone 087-4019690. It is entirely your decision to take part. Thank you very much for taking the time to read this leaflet.

Who do I contact if I have concerns about the study and wish to contact an independent person?

The Secretary, Dublin City University Research Ethics Committee, c/o Research and Innovation Support, Dublin City University, Dublin 9. Tel 01-7008000

Appendix C: Information Sheet for Couple Participants

DUBLIN CITY UNIVERSITY

SCHOOL OF NURSING AND HUMAN SCIENCES
INFORMATION LEAFLET FOR A RESEARCH PROJECT

Title of study: Understanding Vaginismus in the Irish Context: A Qualitative Study.

Supervisors: Dr. Rosaleen McElvaney and Dr. Rita Glover

Principal Investigator: Maria McEvoy
School of Nursing and Human Sciences
Dublin City University, Collins Avenue, Dublin 9

Email: maria.mcevoy26@mail.dcu.ie

Phone: 087 4019690

Introduction

This leaflet is designed to give you some information about a research project on the experience of couples with vaginismus that I am conducting as part of my PhD studies. Participation in the project is voluntary and it is entirely up to you whether you wish to take part. This study has been approved by the DCU Ethics Committee.

Who will participate in the research?

Couples who are over the age of eighteen, and who have experienced vaginismus in their relationship will be invited to share these experiences as part of the study. The woman who has experienced vaginismus must have grown up in Ireland. In addition, health care providers will also be asked to share their experience of working with couples.

What is the research about?

This study is interested in the experience of vaginismus from the perspective of Irish couples. It also seeks to find out what couples and health professionals think about the availability and quality of treatment for vaginismus in Ireland. Couples and health professionals will be asked to take part in an interview about their understanding of vaginismus and their assessment of the current provision of care in Ireland. The results of the study will be available at DCU library in the form of a PhD thesis and also as published material.

What will participation involve?

If you decide to participate in the study, you will be interviewed with your partner about the experience of vaginismus in your relationship and your experience of attempts to seek help. Each interview should take about one hour to ninety minutes. The interviews will be conducted at a mutually agreed location and time. All the interviews will be audio-taped.

Why might you want to get involved?

At present, there is little information about vaginismus in Ireland or from the point of view of both partners. The research study, therefore, seeks to develop a theory of vaginismus from the perspective of Irish couples. It is hoped that this new understanding of vaginismus from their perspective will have a beneficial impact on the future understanding and sensitive treatment of all couples by health care professionals.

Are there any risks?

There may be some risk of emotional upset involved due to the sensitive nature of the topic. However, agreeing to take part in the interview does not mean that you are obliged to answer questions that you are not comfortable with. Prior to the interview, the list of topics will be provided to you so that you know in advance what kinds of things you will be asked on the day to minimize this risk. At any point in the study, you are free to withdraw fully from the study or to postpone the interview to another mutually agreed date and time. The principal investigator can also provide you with information on counselling services should you feel that you need to speak to someone. You will be offered the opportunity to review the transcripts with the principal investigator and to make any amendments and to give feedback on the interview. Your feedback will also be audio-taped.

What about confidentiality?

Your anonymity and the confidentiality will be protected but all information can be subject to subpoena by the Data Protection Act (1998) and the Freedom of Information Act (2000). The only people with access to the information from the interviews will be the researcher herself and her supervisors. The transcripts of the interviews will be stored securely in the form of electronic transcribed material on an encrypted password protected desktop computer. Some direct quotations from the interviews will be used for illustrative purposes but no identifying information will remain linked to the data, only pseudonyms will be used in publications and in the thesis

How do I get involved?

If you are interested in taking part, please contact Maria McEvoy at the following email address: maria.mcevoy26@mail.dcu.ie or alternatively, write to Maria McEvoy at the School of Nursing and Human Sciences, Dublin City University, Collins Avenue, Dublin 9 or phone 087-4019690. It is entirely your decision to take part. Thank you very much for taking the time to read this leaflet.

Who do I contact if I have concerns about the study and wish to contact an independent person?

The Secretary, Dublin City University Research Ethics Committee, c/o Research and Innovation Support, Dublin City University, Dublin 9. Tel 01-7008000

Appendix D: Consent Form for Professional Participants

DUBLIN CITY UNIVERSITY
SCHOOL OF NURSING AND HUMAN SCIENCES
Informed Consent - Professionals

The title of the research study is "Understanding Vaginismus in the Irish Context: A Qualitative Study." The purpose of the research is to develop a theory of vaginismus within the context of Irish culture. The study seeks to understand vaginismus from the perspective of couples and service providers.

Participant – please complete the following (Circle Yes or No for each question)

I have read the Information Leaflet (or had it read to me)	*Yes / No*
I understand the information provided	*Yes / No*
I have had an opportunity to ask questions and discuss this study	*Yes / No*
I have received satisfactory answers to all my questions	*Yes / No*
I am aware that my interview will be audiotaped	*Yes / No*

I understand that participation in the study is voluntary and that I may withdraw from the study at any point. I understand that only people with access to the information from the interviews will be the principal investigator and her supervisors. I am aware that my anonymity and the confidentiality of any information disclosed will be protected, but that this information can be subject to subpoena by the Data Protection Act (1998) and the Freedom of Information Act (2000). Assurances of confidentiality are subject to legal limitations. The transcripts of the interviews will be stored securely in the form of electronic transcribed material on an encrypted password protected desktop computer. Some direct quotations from the interviews will be used for illustrative purposes but no identifying information will remain linked to the data, only pseudonyms will be used in publications and in the thesis.

I have read and understood the information in this form. My questions and concerns have been answered by the researchers, and I have a copy of this consent form. Therefore, I consent to take part in this research project.

Participants Signature: ______________________________

Name in Block Capitals: ______________________________

Witness: ______________________________

Date: ______________________________

For additional information, please contact:

Maria McEvoy	Principal Investigator	maria.mcevoy26@mail.dcu.ie	Tel :087-4019690
Dr. Rosaleen McElvaney	Supervisor	rosaleen.mcelvaney@dcu.ie	
Dr. Rita Glover	Supervisor	rita.glover@dcu.ie	

Appendix E: Consent Form for Couple Participants

DUBLIN CITY UNIVERSITY
SCHOOL OF NURSING AND HUMAN SCIENCES
Informed Consent - Couples

The title of the research study is "Understanding Vaginismus in the Irish Context: A Qualitative Study." The purpose of the research is to develop a theory of vaginismus within the context of Irish culture. The study seeks to understand vaginismus from the perspective of couples and service providers.

Participant – please complete the following (Circle Yes or No for each question)

I have read the Information Leaflet (or had it read to me)	*Yes / No*
I understand the information provided	*Yes / No*
I have had an opportunity to ask questions and discuss this study	*Yes / No*
I have received satisfactory answers to all my questions	*Yes / No*
I am aware that my interview will be audiotaped	*Yes / No*

I understand that participation in the study is voluntary and that I may withdraw from the study at any point. I understand that only people with access to the information from the interviews will be the principal investigator and her supervisors. I am aware that my anonymity and the confidentiality of any information disclosed will be protected, but that this information can be subject to subpoena by the Data Protection Act (1998) and the Freedom of Information Act (2000). Assurances of confidentiality are subject to legal limitations. The transcripts of the interviews will be stored securely in the form of electronic transcribed material on an encrypted password protected desktop computer. Some direct quotations from the interviews will be used for illustrative purposes but no identifying information will remain linked to the data, only pseudonyms will be used in publications and in the thesis.

I have read and understood the information in this form. My questions and concerns have been answered by the researchers, and I have a copy of this consent form. Therefore, I consent to take part in this research project.

Participants Signature: **(1)**____________________ **(2)**________________

Names in Block Capitals: **(1)**____________________ **(2)**________________

Witness: ____________________________

Date: ____________________________

For additional information, please contact:

Maria McEvoy	Principal Investigator	maria.mcevoy26@mail.dcu.ie	Tel :087-4019690
Dr. Rosaleen McElvaney	Supervisor	rosaleen.mcelvaney@dcu.ie	
Dr. Rita Glover	Supervisor	rita.glover@dcu.ie	

Appendix F: Interview Schedule for Professionals

1. How do clients initially approach your service?

2. How do you typically deal with clients when they first come?

Prompts: Do you usually see clients individually or do you see both partners together? Why?
How do you manage the first meeting with the woman/couple?

3. Tell me about the treatment you offer?

Prompts: What is the first stage of responding to a woman/couple presenting with vaginismus?
How would the treatment typically progress?

4. In your opinion, what are the factors that contribute to and maintain the symptoms of vaginismus?

5. Tell me about your experience of treating couples?

Prompts: In your opinion is the treatment generally successful?
When is it successful and when is it less successful?

6. Tell me about your experience of women having an internal pelvic exam?*

Prompts: Where women find this difficult, what are your thoughts on this?*
What have the women told you about this?*

7. In your experience, what do you find helps couples overcome vaginismus?

8. In your opinion, are the most beneficial treatments?

Prompts: Which are available in Ireland?

9. What changes, if any, would you like to see in the provision of care in Ireland?

* Questions based on measures used in the following study: Huber, J. D., Pukall, C. F., Boyer, S. C., Reissing, E. D., & Chamberlain, S. M. (2009). "Just relax": Physicians' experiences with women who are difficult or impossible to examine gynecologically. *Journal of Sexual Medicine, 6*, 791-799.
These questions will only be used when appropriate to do so, i.e. not every health professional will perform internal examinations.

Appendix G: Interview Schedule for Couples

1. When did you first notice that there was a sexual difficulty?

Prompts: What did you notice?
How did it develop over time? If so, what have you noticed?

2. When the difficulty became apparent, how did you cope with it?

Prompts: How did you respond?
How did your partner respond?

3. Tell me about the impact vaginismus has had on your relationship?

Prompts: Did vaginismus make you feel differently about yourself?
Did vaginismus make you feel differently about your relationship?

4. Tell me about how you sought help?

Prompts: Tell me about your experience of seeking help.
What type of help did you seek?
Did you look online for information? Did you find the information helpful?
Did you talk to anyone else about the difficulty? Was this helpful?

5. Can you describe your experience of going for professional help?

Prompts: What kinds of treatments were available to you?
Can you describe your experience of these treatments?
Did treatment help?
Did you gain any insight about what might have contributed to the vaginismus? e.g. Events, Personal Disposition and History

6. I would like to ask you some questions about what ideas you might have about what led to these difficulties.
   (a) Can you tell me about how you first learned about sex and sexuality?
   (b) Was sex openly spoken about at home?
   (c) What was the attitude to sex in the home?
   (d) What was the reaction if scenes of a sexual nature were to come on TV at home?
   (e) Did you receive any formal sex education in school? Can you describe it?
   (f) What do you think has influenced your views on sex?

If the vaginismus was resolved…
How did you know when it had been resolved?
If it did help, how did they help in the short-term/long-term?
What do you think has been most beneficial to you?

If the vaginismus was not resolved…
If treatment was not beneficial, tell me what was not helpful.
What, do you think, are the main obstacles to overcoming vaginismus?

7. What is your overall assessment of going for professional help?
How would you have liked to have been treated?
What changes, if any, would you like to see in the provision of care in Ireland?

Appendix H: Interview Schedule for Couples Follow Up Session

1. How was the interview for you?
2. Are there any questions that I should have asked but didn't?
3. If another couple came to you for help, what advice would you give them?

Appendix I: Screenshot of NVivo Database Exported to Excel Open Coding Analysis 29th August 2020

AutoSave OFF FINAL Coding Examples for Appendices Jan21

Home Insert Draw Page Layout Formulas Data Review View

Paste Calibri (Body) 12 Number Conditional Format as T Cell Styles

E36 fx

	A	B	C	D	E	F	G
1	**LOWER LEVEL CATEGORIES**						
2	1. Emotional needs are not met						
3	Parents Relationship Difficulties						
4	2. Communication about sex is a no go area						
5	3. Perception of sex in the home is predominantly negative						
6	Perception of sex is threatening						
7	Fear of pregnancy from a timing perspective						
8	Embarrassment surrounding sexual matters						
9							
10	1. Very sensitive to shame and hurt						
11	2. Anxiety is extreme						
12	3. Puts the needs of others before her own						
13	4. Need to feel in control						
14							
15	1. Irish culture of silence and control of female sexuality						
16	Negative religious messages about sex						
17	Shame surrounding sexual matters						
18	2. Sex education in Ireland is inadequate						
19	3. Communication with peers about sex is isolated and shaming						
20							
21	1. Her body is not her friend						
22	Her whole life is guilt						
23	Negative experiences with physical exams						
24	Body is associated with physical and psychological pain						
25	Tampons were not used						
26	2. I am the only one						
27	Low self esteem can affect and be affected by vaginismus						
28	Her whole life is guilt						
29	3. Vaginismus is a meaningful psychosomatic symptom						
30	Adult self does not develop						
31	Threats and ultimatums hinder resolution						
32	Vaginismus can be secondary or situational in nature						
33							

34	1. Endless attempts at failed or painful sexual intercourse
35	Understanding vaginismus as painful or impossible sex
36	2. Intimacy can affect and be affected by vaginismus
37	Couple lifestyle does not allow space for each other
38	Communication about sexual matters is difficult for the couple
39	3. Partner puts her needs before his own
40	Partner is unable to care for her emotional needs
41	
42	1. Medical professionals may not be adequately informed about psychosexual difficulties
43	GPs need to give patients permission to discuss sexual matters
44	Understanding vaginismus as something to be medically fixed
45	2. Referrals from doctors can add to the confusion
46	Diagnosis by physical examination usually by GPs
47	Understanding vaginismus as a physical problem
48	3. Difficulty accessing services causes further distress
49	Systems of referral are difficult to navigate
50	Searching for information in the media can be hit and miss
51	4. Awareness of vaginismus is needed for greater understanding
52	Understanding vaginismus as the legacy of sexual abuse
53	Understanding vaginismus as a common problem
54	
55	1. Relationships are sound despite the vaginismus
56	2. Sexual in other ways
57	3. A decision is made to resolve the problem
58	
59	1. The therapeutic relationship can help with understanding and overcoming vaginismus
60	Understanding facilitating factors can shed light on vaginismus
61	Understanding vaginismus as psychological (couple)
62	Control over pelvic floor muscles empowers
63	Stumbling blocks stall the therapeutic process
64	Need to fix the broken self (quickly)
65	Couples have a tendency toward rumination and spectatoring
66	Challenging entrenched beliefs contributes to overcoming difficulties
67	Mindfulness and relaxation help overcome anxiety
68	Encouragement and empowerment by the therapist is needed to progress
69	2. Vaginismus can be more effectively resolved together as a couple
70	Couple work helps with communication
71	Sensate focus helps to connect with the self and partner
72	Successful outcome is defined by more than penetrative sex
73	

Appendix J: Screenshot of NVivo Database Exported to Excel Context and Process Coding Analysis 29th August 2020

	A	B
1	**CORE CATEGORY:** DISCONNECTING AND RECONNECTING	
2	**Higher Level Category/CONTEXT [Meaning attached to those conditions]**	**Lower Level Category [Conditions]**
3	Lack of emotional support from caregivers	1. Emotional needs are not met
4		Parents Relationship Difficulties
5		2. Communication about sex is a no go area
6		3. Perception of sex in the home is predominantly negative
7		Perception of sex is threatening
8		Fear of pregnancy from a timing perspective
9		Embarrassment surrounding sexual matters
10		
11	Pleasing others and denying emotional needs	1. Very sensitive to shame and hurt
12		2. Anxiety is extreme
13		3. Puts the needs of others before her own
14		4. Need to feel in control
15		
16	Sex is percieved as threatening and shameful	1. Irish culture of silence and control of female sexuality
17		Negative religious messages about sex
18		Shame surrounding sexual matters
19		2. Sex education in Ireland is inadequate
20		3. Communication with peers about sex is isolating and shaming
21		
22	The sexual self is experienced as confusing and threatening	1. Her body is not her friend
23		Perception of the body being broken
24		Negative experiences with physical exams
25		Body is associated with physical and psychological pain
26		Tampons were not used
27		2. I am the only one
28		Low self esteem can affect and be affected by vaginismus
29		Her whole life is guilt
30		3. Vaginismus is a meaningful psychosomatic symptom
31		Adult self does not develop
32		Threats and ultimatums hinder resolution
33		Vaginismus can be secondary or situational in nature
34		
35	Experiencing intimate relationships as emotionally challenging	1. Endless attempts at failed or painful sexual intercourse
36		Understanding vaginismus as painful or impossible sex
37		2. Intimacy can affect and be affected by vaginismus
38		Couple lifestyle does not allow space for each other
39		Communication about sexual matters is difficult for the couple
40		3. Partner puts her needs before his own
41		Partner is unable to care for her emotional needs
42		
43	Accessing accurate information is hit and miss	1. Medical professionals may not be adequately informed about psychosexual difficulties
44		GPs need to give patients permission to discuss sexual matters
45		Understanding vaginismus as something to be medically fixed
46		2. Referrals from doctors can add to the confusion
47		Diagnosis by physical examination usually by GPs
48		Understanding vaginismus as a physical problem
49		3. Difficulty accessing services causes further distress
50		Systems of referral are difficult to navigate
51		Searching for information in the media can be hit and miss
52		4. Awareness of vaginismus is needed for greater understanding
53		Understanding vaginismus as the legacy of sexual abuse
54		Understanding vaginismus as a common problem
55		
56	Experiencing the relationship as a way of connecting with disconnected	1. Relationships are sound despite the vaginismus
57	aspects of the self	2. Sexual in other ways
58		3. A decision is made to resolve the problem
59		
60	Experiencing therapy as a way for both partners to connect in the relationship	1. The therapeutic relationship can help with understanding and overcoming vaginismus
61		Understanding facilitating factors can shed light on vaginismus
62		Understanding vaginismus as psychological (couple)
63		Control over pelvic floor muscles empowers
64		Stumbling blocks stall the therapeutic process
65		Need to fix the broken self (quickly)
66		Couples have a tendency toward rumination and spectatoring
67		Challenging entrenched beliefs contributes to overcoming difficulties
68		Mindfulness and relaxation help overcome anxiety
69		Encouragement and empowerment by the therapist is needed to progress
70		2. Vaginismus can be more effectively resolved together as a couple
71		Couple work helps with communication
72		Sensate focus helps to connect with the self and partner
73		Successful outcome is defined by more than penetrative sex

Appendix K: Screenshot of NVivo Database Exported to Excel Context and Process Coding Analysis 29th August 2020

Row	A	B
1		**CORE CATEGORY:** DISCONNECTION AND CONNECTION
2	**AXIAL CODES/PROCESS**	**Higher Level Category/CONTEXT [Meaning attached to those conditions]**
3	**SUB CORE CATEGORY 1:**	Lack of emotional support from caregivers
4	**PROTECTIVE DISCONNECTION**	
5	Disconnection from the Sexual Self	
6	[Action]	
7		Pleasing others and denying emotional needs
8		
9		
10		
11		Sex is perceived as threatening and shameful
12		
13		
14		
15		The sexual self is experienced as confusing and threatening
16		
17		
18		
19	**SUB CORE CATEGORY 2:**	Experiencing intimate relationships as emotionally challenging
20	**ATTEMPTS AT CONNECTION**	
21	Seeking Sexual Connection	
22	[Action]	
23		
24		Accessing accurate information is hit and miss
25		
26		
27		
28	**SUB CORE CATEGORY 3:**	Experiencing the relationship as a way of connecting with disconnected
29	**HEALING CONNECTION THROUGH RELATIONSHIPS**	aspects of the self
30	Connection with the Sexual Self and the	
31	Sexual Relationship	
32	[Action]	Experiencing therapy as a way for both partners to connect in the
33		relationship
34		
35		